REFERRAL, INTAKE AND ELIGIBILITY DETERMINATION

1. Referral Form
2. Neonatal Intensive Care Unit (NICU) Referral Form
3. Combined Enrollment Form and Social History Interview Instructions
4. Combined Enrollment Form
5. Social History Interview Form
6. Determination of Need for Educational Surrogate Appointment
7. Early Intervention Record Access Log
8. Health Summary
9. Getting to Know Our Child Worksheet
10. Getting to Know Our Child Instructions
11. Authorization Form - Evaluation/Assessment/Teaming
12. Assessment Reporting Guidelines
13. Eligibility Criteria
14. Eligibility Determination Documentation
15. Eligibility Determination Instructions
16. Meeting Notification
17. First Steps Brochure Order Form

MISSOURI FIRST STEPS EARLY INTERVENTION SYSTEM
REFERRAL FORM

Please complete form with the information you have available at this time.

COMPLETED BY:	*REFERRAL DATE:

CHILD'S INFORMATION:

*Name: _____ *Date of Birth: _____ *Gender M F Ambiguous
Last First Middle

*Address: _____
Apartment/Street/Post Office Box Number

*City/Town: _____ MO *Zip Code _____ *County _____

FAMILY INFORMATION:	FAMILY INFORMATION:
*Parent's Name: _____ Last First Middle	*Parent's Name: _____ Last First Middle
*Relationship:_____	*Relationship:_____
*Address:_____	*Address:_____
*City/Town:_____*State:_____ *Zip Code:_____	*City/Town:_____*State:_____ *Zip Code:_____
*Home Phone:_____ *Work Phone: _____	*Home Phone:_____ *Work Phone: _____
Alternate Contact: _____	Alternate Contact: _____
Relationship:_____Phone:_____	Relationship:_____ Phone:_____

*REASON FOR REFERRAL: _____

Medical Diagnosis: _____ NO _____ YES: What? _____

Has this family been informed of this referral? _____ Yes _____ No: If no, how do you plan to inform? _____

REFERRAL SOURCE INFORMATION:

*Name: _____ Agency: _____

Address:_____ City/Town:_____ State:_____Zip Code:_____

*TEL:_____ FAX: _____

*How did you find out about First Steps ?_____

Intake Coordinators Name: _____ Date Assigned: _____

*Indicates information entered and stored electronically at the System Point of Entry.

March 03

MISSOURI FIRST STEPS EARLY INTERVENTION SYSTEM
NEONATAL INTENSIVE CARE UNIT (NICU) REFERRAL FORM

*Referring Hospital:		*Date of Referral:	
Address:		*Telephone:	FAX:
City/Town:	State: Zip:		
Completed by:	Referring Physicians Signature: _____		
*Primary Medical Care Provider:		*Telephone:	FAX:
*Address:			
*City/Town:	* State: *Zip:		
The family has been informed of this referral.	The family has not been informed of this referral at this time.		
*Child's Name:		*DOB:	*Male/Female/Ambiguous
*Parent/Guardian Name:			
*Address:			
*City/Town:	*State: * Zip:		
*Telephone:	Other contact information:		
	Is child currently hospitalized?	YES	NO
Birth Weight / Gestational Age	*APGAR Scores @ 1 min:	@ 5 min:	@10 min:
DIAGNOSIS:			
COMMENTS:			

FAX THIS REFERRAL FORM TO: FIRST STEPS AT

OR MAIL TO:

Intake Coordinator Name: _____ Date Assigned: _____

***Indicates information entered and stored electronically at the System Point of Entry.**

March 03

INSTRUCTIONS FOR
COMBINED ENROLLMENT FORM AND SOCIAL HISTORY INTERVIEW

The **COMBINED ENROLLMENT FORM** is the product of the Missouri partnership between the Department of Elementary and Secondary Education (DESE) on behalf of the state's First Steps early intervention system, and the Department of Health and Senior Services (DHSS) on behalf of the Bureau of Special Health Care Needs (BSHCN), the Department of Mental Health (DMH), Division of Mental Retardation and Developmental Disabilities (MRDD) and the Department of Social Services (DSS), Missouri MC+ Program. It is used to submit all participant related information to the Central Finance Office (CFO), DHSS/BSHCN, DMH/MRDD and DSS/MC+ computer systems. The Combined Enrollment Form is three pages in length and is shared with affiliate agencies when conducting a referral, based upon family interest and consent. It is accompanied by the Social History Interview, which focuses on a variety of questions pertinent to the potential eligibility of the young child, unique family needs, and resources, supports and services currently in place for the child and family from the First Steps perspective.

The Combined Enrollment Form contains three pages of demographic, income and insurance information and is supplemented by the eight page Social History Interview. Either or both of these forms may be shared, with informed parent consent, with other participating agencies and providers as appropriate. The purpose of these documents is to reduce the need for the family to retell their story by collectively gathering, organizing and distributing key information to the variety of individuals who require this information through a signed **Release of Information** form. The family receives a copy of this document once completed and is assisted by their Service Coordinator to make revisions and updates to the information as needed.

The combined form was jointly developed by DESE, DHSS/BSHCN, DMH/MRDD and DSS/MC+ to be used by all four (4) programs. This combined enrollment form is an effort to help coordinate program activities and to avoid duplication of data collection in those areas where one or more of these programs operate. The family must consent to distribution of this information. There will likely be additional information required by the receiving agency, but this will not duplicate the information contained in either of these forms.

GENERAL INPUT CONSIDERATIONS

The multi-part form is divided into 13 major sections, many of which contain sub-sections. With a few exceptions, all sections appropriate to a specific category/status of a participant are critical sections and require an entry. Consequently, reasonable care must be taken in the storage and handling of these forms. If there is no response for an individual item, please write in N/A for not applicable; do not leave blank spaces.

The following general rules of input should be observed when completing the **combined enrollment form and social history interview**:

- The form must be completed using a medium ballpoint pen (not felt tip) in either **black or blue ink** to ensure clear reproduction as needed.
- All entries should be clearly printed within the appropriate sections.

DETAILED SECTION DESCRIPTIONS

The following is a detailed section-by-section description of the **Combined Enrollment Form**. The form is used for First Steps enrollment, and will facilitate easy referral for BSHCN, MRDD and MC+ programs. Information collected on the enrollment form must be REVIEWED and updated as needed on at least ANNUALLY. This does not include the social history. Due to the different needs and requirements of each program, some of the data sections are to be completed only by a specific program and are not necessarily to be completed by all four state agencies.

PART I ENROLLMENT APPLICATION

FIRST STEPS SECTION

SPOE Number: Enter SPOE identification number.

I.D. Number: Enter the participant's identification number assigned by the CFO.

New Referral: This box is to be checked when adding a new participant who has never been enrolled in the First Steps program.

Re-referral: Check this box if the family had begun the referral process at an earlier date and re-entered the First Steps eligibility determination process at this point. This box will not be used for participants that have been closed, or previously ineligible.

Annual Update: Check this box if the family has completed the annual IFSP review concurrent with the annual evaluation of the IFSP.

Other: Check if the family has come to the SPOE for completion of the application for other reasons than First Steps enrollment. Indicate reason.

DHSS/BSHCN SECTION

Leave blank for agency to complete. Send to local office for processing. Locations for local offices can be found at www.dhss.state.mo.us/SHCN/mainmap.htm.

DMH/DMRDD SECTION

Leave blank for agency to complete. Send to local office for processing. Locations for local offices can be found at www.modmh.state.mo.us/maps/mrddmap.htm

DSS/MC+ SECTION

Medicaid application can be downloaded from www.dss.state.mo.us/mcplus/address.htm**. All information needed for this application can be found in the combined enrollment. Submit only the application located at the above website. MC + for children applications can be submitted to local offices. Locations for local offices can be found at** www.dss.state.mo.us/mcplus/address.htm**.**

Section A. CHILD INFORMATION

Last Name/First Name/MI:	Write the last name, first name and middle initial in the space provided under the identified field. This should be the participant's legal name and not a nickname. Only enter one child's name in this section.
Date of Birth:	Use numerical entries 00/00/00 (mo/day/year)
Also Known As (AKA):	Complete if applicant is known by another name.
Street Address:	This is the participant's street address, inclusive of apartment number, rural route, box number etc. Commonly known abbreviations are acceptable.
NOTE:	For a homeless person with no address, either the word NONE or the SPOE address may be entered. If possible, obtain an address where the homeless person may receive mail for notification of approval or denial, etc.
City/Town/State:	This is the name of the city or town where the participant resides and the state.
Zip Code:	The participant's postal zip code appropriate for his/her address.
Telephone Number:	This telephone number identifies the location where the participant's parent or legal guardian may be reached. A/C means Area Code.
Mother's Maiden Name:	This is helpful for participant identification purposes in reducing potential duplication of records.
Child's Native Language:	This identifies the child's main means of communication or mode of communication including English, other languages (be specific) including American Sign Language, or augmentative communication devices.
Child's Resident School District:	Record the district in which the child resides.

Section B. PARENT/LEGAL GUARDIAN

Last Name/First Name/MI:	The parent or legal guardian's name should be entered here. When enrolling in the First Steps Program, a child may have an Educational Surrogate in lieu of a parent or legal guardian for the purpose of seeking early intervention services. In such circumstances, the Educational Surrogate's name should be used.

Address if Different from Applicants Address:
Include the address of the person identified in Section B if the address is different from the child.

City/Town/State: This is the name of the city or town where the participant resides and the state.

Zip Code: The participant's postal zip code appropriate for his/her address.

Telephone Number: This telephone number identifies the various locations where the participant's parent or legal guardian may be reached.

Native Language at Home: This identifies the language or mode of communication normally used by the parent.

Interpreter: Does the family need an interpreter for any meetings concerning the provisions of Part C services. Answer yes or no.

Record the name of the Intake Coordinator who conducts the initial interview, or the Service Coordinator who reviews this information on an ongoing, routine basis with the family (minimally prior to the annual evaluation of the IFSP). The business mailing address and primary telephone should be inserted in the space provided.

The Combined Enrollment Form may be conducted with families on an inter-periodic basis if their needs or eligibilities change, such as in the case of unemployment.

Section C. List all persons (including the child) who live in your household and provide the requested information for each individual.
Household means all the persons who occupy a housing unit (house or apartment), whether they are or are not related to one another, and who are living together as an economic unit.

Name: Enter the names of all individuals living within the "household" (as defined above). Start with the name of the child for whom First Steps referral has been made.

Relationship: Relationship to the participant identified in Section A. Record either the title acronym for the relationship or enter the codes listed below. Record "self" for the child for whom this referral has been made.

1. Mother
2. Father
3. Brother
4. Sister
5. Half-Brother
6. Half-Sister
7. Stepfather
8. Stepmother
9. Stepsister
10. Stepbrother
11. Foster Father
12. Foster Mother
13. Grandfather
14. Grandmother
15. Uncle
16. Aunt
17. Other
18. Guardian
19. Educational Surrogate
20. DFS Case Worker

DOB: Enter the date of birth using numerical entries 00/00/00 (mo/day/year)

Marital Status: List as appropriate.
Codes are: M = Married
S = Single
D = Divorced

Gender: Enter M (male), F (female) or A (ambiguous)

Race/Ethnicity Information: Two codes should be recorded in this section, separated by a "/".

Race: Use one of the numerical codes listed below to identify race as per the participants stated preference or, if none is stated, based on the visual observation of the SPOE staff. Follow the code with a slash (/) to separate the ethnicity code.

1. White (not Hispanic)
2. Black, African American (not Hispanic)
3. American Indian or Alaska Native
4. Asian/Pacific Islander
5. Hispanic / Latino

Ethnicity Information should be recorded as follows:

1) No, not Spanish/Hispanic/Latino
2) Yes, Mexican, Mexican American, Chicano
3) Yes, Puerto Rican
4) Yes, Cuban
5) Yes: Other Spanish/Hispanic/Latino

Nationality Information should be recorded as follows:

1. Asian Indian
2. Filipino
3. Other Asian: Print Race as reported by family precisely in the comment section provided on this page
4. Japanese
5. Korean
6. Vietnamese
7. Native Hawaiian
8. Guamanian or Chamorro
9. Samoan
10. Other Pacific Islander: Print Nationality as reported by family precisely in the comment section provided on this page
11. Some other nationality: Print nationalities precisely as reported by the family in the comment section provided on this page.

Migrant/Homeless: Indicates the status of the participant as a migrant farm worker or a homeless person. If the person is both migrant and homeless, code as a migrant. (Only Missouri residents may make application to the DOH/BSHCNS.)

Codes are:
1 = Non-migrant and not homeless
2 = A homeless individual who lacks a fixed, nighttime residence, e.g., is sleeping on the street, in a car, etc.
3 = A homeless individual whose primary nighttime residence is a shelter.
4 = A homeless individual whose primary nighttime residence is a temporary facility designed for individuals who should be institutionalized.
5 = A homeless individual whose primary nighttime residence is temporarily in someone else's home.
6 = A homeless individual whose primary nighttime residence is a public or private place not designed as a regular sleeping place (i.e., church, etc.).

Educational Level: Indicates the highest-grade level competed by each household member. Use "0" to indicate none.

Codes are:
1 through 8 = grade school / middle school
9 through 12 = high school
13 through 16 = undergraduate or technical school
17 through 20 = graduate school

Pregnant (Y/N) # fetuses: Enter Yes (Y) or No (N) when appropriate for each female household member. Some resources will include the unborn fetus in the determination of household size. If it is known that this will be a multiple birth, provide the number of fetuses in this section.

US Citizen: Enter Yes (Y) or No (N) if household member is a US citizen if applying for MC+ for the listed person. If not, provide documentation on how they are in the country. Use the comment section to record this information.

PCP (Y/N): Enter Yes (Y) or No (N) whether each person has a primary care physician or PCP.

SSN#: Social Security Number: Enter the child's 9 digit social security number. All children must have a SSN over the age of one (1) month. MC+ requires that each applicant must have applied for or received a SSN. Provide the SSN for each individual for whom an MC+ application is being made.

DCN#: This is the Missouri MC+ recipient identification number

Check if applying for MC+: This application can be used to enroll several family members within the MC+ program.

Total Household: Total the number of individuals reported above and who reside in this home.

Adjusted Household: Will be completed by other state resources if referral is made (e.g., WIC). DO NOT COMPLETE.

Total Applying for MC+: Enter the total number of household members who are applying for MC+.

Section D. Income Verification

Total Household Gross MONTHLY Income: Record per family's report. Not required for application to First Steps. If a family does not want to Provide this information enter $99.99 for data entry purposes only.

Is Someone in the Household Employed: Mark "yes" or "no" depending on response. If yes indicate name of person employed.

Proof of Income Verification: The family should provide some written documentation that verifies the income information provided in the earlier section. The Intake/Service Coordinator should visually review this, record the type of verification provided by circling appropriately, and sign in the space provided.

If no income, ask the child's parent/guardian how the child is supported.

The purpose of asking if this income is the same as the last three months is to identify those families with seasonal income, which may mean eligibility variations over time.

A series of questions follow that identify extraordinary situations that affect a family's income, or ability to work. These questions help to identify additional resources that may benefit a family, as well as help to establish particular exemptions or special considerations related to income eligibility for various resources and supports that the child/family may be eligible for.

Child Care: Missouri has resources to assist families in locating and paying for child care in order to be employed. This question helps to identify the potential for referral for these supports.

Is the child: Check appropriately (Yes/No) if the child is Blind/Disabled, and if they are currently receiving Supplemental Security Income (SSI) due to a verified disability.

Family Care: Families may be helping to support or care for another family member who is not able to care for themself. This would include the care (in home or out of the home) provided for a parent/grandparent, sibling, etc.

Support Payments: Consideration is often extended to income determination when child support payments are being made by one or both parents.

Extraordinary Expenses: Check Yes/No if the family has extraordinary expenses based upon the special health or developmental needs of the child or other children in the family, or other family members. This may include costs of specialized care, medications, education, transportation, utilities, etc. Use the comment section to detail these expenses.

Section E. Medical Insurance Summary

Information concerning the existing health insurance for the child should be summarized in this section. The Intake/Service Coordinator should assist the family to review their insurance policy in responding to these questions about benefit coverage. This helps the family to understand what their coverage actually provides related to their child's potential needs, and will assist in appropriate determination of the use of insurance for IFSP services.

E.1. This is identification information for the child referred to First Steps.

E.2. If the child is enrolled in MC+, provide application and coverage information in this section.

E.3. If other insurance is available for the child, insert the name and information of the parent/family member who is the Policyholder.

E.4. Insurance Company Information. Insert contact information for this policy.

E.5. Policy Number and group information is provided on the insurance card that the family will have.

E.6. If this coverage is obtained through an employer, please list the name of the employer and contact information.

E.7. Specific coverage information will be detailed in the policy, or can be obtained by calling the benefits coordinator at the employer or the Insurance company directly.

The individual who assisted the family to collect and record this information should sign their name and indicate their affiliation by checking the appropriate box.

Families should be given a copy of this completed form for their records. This form should be routinely reviewed, at least annually, for changes that may prompt additional referral options based upon the changing situations that the family has encountered.

SOCIAL HISTORY INTERVIEW:

The name and date of birth of the child should be entered on each individual page of this interview form.

Section A.

Date of Interview: Enter the date the Social History Interview was completed.

Interviewer: Indicate the person who asked the questions and completed the interview for the social history.

Information Provided by: Indicate who, by name and relationship to the child, provided the information for the social history interview.

Section B. Reason For Referral

This section is intended to learn from the family what their perception of the child's needs are, and why a referral was appropriate. This information may be different from information provided by the referral source, if different from the family. A short statement of the medical concerns for application to the BSHCN program is necessary. If there is a medical diagnosis, document this information in the section provided. You may attach documentation of this diagnosis if available.

Section C. Screening/Assessment/Testing Service History

This section is applicable for participants who indicate that assessments and/or screenings have been completed. It is important to record the results to provide follow-up by the First Steps Service Coordinator when the child is enrolled in various programs. This section is intended to collect information to assist in eligibility determination and to avoid duplication.

Section D. Health Care Received in the Past 12 Months

This page should be copied as many times as needed to record the various sources of health and medical care that the child has received in the past 12 months. The Intake/Service Coordinator will be better able to identify individuals who can provide additional information related to eligibility, thus avoiding duplication for the family. The Intake/Service Coordinator should also identify with the family those individuals who should be involved in the child's eligibility determination and service planning should the child be eligible. This section is intended to record routine medical care as well as specialty care. Include the name and contact information for each provider, the reason that the provider saw the child and circle the type of provider that this is.

Section E. What is Happening Now for Your Child?

E.1 and 2 indicate the equipment, supplies, medications, and/or special diet that may be utilized by the child.

E.3 is used to identify the current medications that the child is taking, the method of administration, and the purpose.

E.4 is used to identify when the child is on a special diet, including when special formula or foods are required and how these are paid for.

Section F. Developmental Milestones

These subsections are necessary for application to the First Steps program. Many times the developmental milestones are important for children applying to the DHSS/BSHCN and Maternal Child Health (MCH) programs. If the developmental milestones have been achieved, check accordingly in the box provided in front of the specific skill area. Use the "comment" section to note any accommodations or considerations to the specific skills. Ask the family if this is a particular area of concern for them, and if so, record their comments in the section provided.

Section G. Pregnancy, Birth and General Health History

These subsections are necessary for application to First Steps. All the other programs may or may not have a need to complete this section. If the pregnancy and birth history has an impact on the services being provided for the participant or family, it would be a required section to complete. Fill in data and check the yes/no responses to the questions of each subsection. Provide any additional information shared during the interview at the end of this section.

Section H. Family information needs

This section provides a recording place for general comments, questions or follow-up information that is generated during the family interview and not recorded elsewhere.

STATE OF MISSOURI
COMBINED ENROLLMENT FORM

DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF SPECIAL HEALTH CARE NEEDS (BSHCN)
DEPARTMENT OF SOCIAL SERVICES
MC+

DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
DIVISION OF SPECIAL EDUCATION - FIRST STEPS
DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES

PART I ENROLLMENT APPLICATION

*COUNTY OF RESIDENCE OF PARTICIPANT	APPLICATION DATE

FIRST STEPS	SPOE	I.D. Number	☐ NEW REFERRAL ☐ ANNUAL UPDATE ☐ RE-REFERRAL ☐ OTHER:
BSHCN	Local Office	I.D. Number	☐ NEW ENROLLMENT ☐ REAPPLICATION ☐ REEVALUATION CHILD IS MEDICALLY: ☐ ELIGIBLE ☐ INELIGIBLE CHILD IS FINANCIALLY: ☐ ELIGIBLE ☐ INELIGIBLE DATE ELIGIBILITY DETERMINED: _____
MRDD	Local Office	I.D. Number	☐ NEW ENROLLMENT ☐ REAPPLICATION ☐ REEVALUATION CHILD IS MEDICALLY: ☐ ELIGIBLE ☐ INELIGIBLE CHILD IS FINANCIALLY: ☐ ELIGIBLE ☐ INELIGIBLE DATE ELIGIBILITY DETERMINED: _____
MC+ For Kids (Medicaid)	☐ NEW ENROLLMENT ☐ REAPPLICATION ☐ PENDING ☐ CURRENT ☐ N/A		

*****Ö **SECTION A. Child Information**

LAST NAME	FIRST NAME			MI	DOB	KNOWN AS (AKA)
STREET ADDRESS, APARTMENT NUMBER, P.O. BOX	CITY/TOWN	STATE	ZIP CODE	A/C	TELEPHONE #	MOTHER'S MAIDEN NAME
Child's Native Language: ☐ English ☐ Spanish ☐ Other:						
Child's School District:						

Ö **SECTION B. Parent/Legal Guardian Information**

1. *Name: _____

*Address: _____
Street City/Town State Zip Code

*Home Telephone: ( ) _____ *Office Telephone: ( ) _____ Other Telephone: ( ) _____

2. *Name: _____

*Address: _____
Street City/Town State Zip Code

*Home Telephone: ( ) _____ *Office Telephone: ( ) _____ Other Telephone: ( ) _____

*Native Language Spoken at Home: _____ Interpreter Needed?_____

*√ Intake Coordinator/Interviewer:	Address:	Telephone:
*√ Ongoing Service Coordinator:	Address:	Telephone:

Child's Name:_____ DOB: Date:

SECTION C. List all persons (including participant) who live in your household and provide requested information for each individual.

Name	*Relationship	*DOB	Marital Status	*Gender	*✓ Race/Ethnicity	Nationality	*Migrant/Homeless	*✓ Education Level	Preg (Y/N) # Fetuses	US Citizen (Y/N)	PCP (Y/N)	* SSN#	*DCN	Ins Y/N	X if applying for MC+
Child:					/										
					/										
					/										
					/										
					/										
					/										
					/										
					/										
					/										

.

TOTAL HOUSEHOLD SIZE _____ ADJUSTED HOUSEHOLD SIZE _____ TOTAL APPLYING FOR MC+ _____

SECTION D. Income Verification

***** √ Are you or someone else in your household currently employed? ☐ YES If yes who _____ ☐ NO

*Total Household Gross MONTHLY Income: $ _____

Proof of Income was verified (check stub, letter, tax form, or written statement) by _____
Signature

If no income, how are you supported? _____

Is this month's income the same as the previous three months? ☐ YES ☐ NO

*Are you currently paying child care to maintain employment? ☐ YES ☐ NO

Is the child: Blind/Disabled? ☐ YES ☐ NO Receiving SSI? ☐ YES ☐ NO

Do you pay for care of an incapacitated adult? ☐ YES ☐ NO

Does anyone living in the household pay support payments? ☐ YES ☐ NO

Do you have any extraordinary expenses? ☐ YES ☐ NO

√ Federal Poverty Level ☐ <0 -100% ☐ <101-125% ☐ <126-133% ☐ <134-150% ☐ <151-185%
☐ <186-200% ☐ <201-250% ☐ <251-300% ☐ >301-400% ☐ >401%

COMMENTS:

Child's Name:_____ DOB: Date:

SECTION E. Medical Insurance Summary (*complete a new form for each insurance coverage*)

1. CHILD IDENTIFYING INFORMATION:

Name: D.O.B.: DCN:

Address: MO

Street City/Town Zip Code

***2. MC+ ENROLLMENT INFORMATION:**

Complete One: Current Coverage Effective Date:

Pending Application Date:

Not Financially Eligible Date of Denial:

MC+ Plan

Contact Info

Did participant lose health insurance coverage in the past 3 months?

☐ YES ☐ NO Date coverage ended:

Reason for loss of insurance:

***3. POLICYHOLDER INFORMATION:**

Name: Relationship: Telephone: ( )

Address:

Street City State Zip Code

***4. INSURANCE COMPANY INFORMATION:**

Name: Telephone: ( )

Address:

Street City State Zip Code

Check As Applicable: Is this Coverage: ____ Through Employer ____ Self Purchase ____ Union ____ HMO Policy ____ PPO Policy

***5. POLICY NUMBER:** Member/I.D. #: Group/Acct. #:

Effective date dependent will be covered under policy: End Date:

6. EMPLOYER INFORMATION:

*Name of Employer:

Address:

Street City State Zip Code

Telephone: ( ) Start Date:

7. COVERAGE INFORMATION: Check As Applicable:

A. Second Insurance Company Coverage? ☐ YES ☐ NO

B. Therapy Services Covered: ☐ OT ☐ PT ☐ Speech

C. Co-Payments? ☐ YES ☐ NO

Office Visit Amt: $ Specialist Amt: $

Emergency Room Amt: $ Other Amt: $

Prescriptions Amt: $ DME Services Amt: $

D. *Deductibles? ☐ YES ☐ NO If YES, Amt: $

E. Maximum Out of Pocket Expense $

F. Is there a pre-existing clause? ☐ YES ☐ NO

Effective Date:

G. Is there a dental plan? ☐ YES ☐ NO

Name of plan if different:

Effec. Date: Term. Date:

H. Lifetime maximum? ☐ YES ☐ NO

$ per person $ per family

I. Conditions/Exclusions:

Confirmation of Information:

(Signature) (Date)

Check One: ☐ First Steps Intake / Service Coordinator ☐ BSHCN Coordinator

☐ DFS Caseworker ☐ DMH Staff

*Indicates information entered and stored electronically at the System Point of Entry

√ Required for First Steps Application

STATE OF MISSOURI
SOCIAL HISTORY INTERVIEW

Missouri First steps EARLY INTERVENTION

Child's Name: _____ Date of Birth: _____

A. Date of Interview: _____

Interviewer:_____ Information Provided By:_____

B. Reason for Referral *

Review the reason(s) for referral with the family members. See original Referral Form for this information. Include medical condition/need requiring assistance. Does the family agree with the referral? Do they see things differently? Briefly summarize this discussion below.

_____

_____

_____

_____

Existing Diagnosis, if known: _____

C. Screening/Assessment/Testing History *

Please list dates of previous screening, assessments or other tests (including birth or developmental screening, vision and hearing, nutrition, speech, gross and fine motor movement, adaptive skills, cognitive abilities, etc.).

Date	Test Administered	By Whom	Results	Date	Test Administered	By Whom	Results
	Vision						
	Hearing						
	Developmental Screen						

*Indicates information to be entered and stored electronically at the System Point of Entry

D. Health Care Received in the Past 12 Months (Copy additional pages of this section as needed) List primary care physician for all well-child care including immunizations, medical care by specialty type, hospitalizations, surgeries within the last twelve (12) months. Include any services including therapies that the child now receives. Summarize contact information.

***PRIMARY CARE PHYSICIAN Name:**	# OF VISITS:	DATE LAST SEEN:	PCP#
*ADDRESS:		*TELEPHONE: ( ) * FAX: ( )	
REASON(S):			

CIRCLE: WELL CHILD CARE/CLINIC SERVICES VISION DENTAL SPECIALTY (TYPE:_____) HOSPITAL: _____

*NAME:	# OF VISITS	DATE LAST SEEN:
*ADDRESS:		*TELEPHONE: ( ) *FAX: ( )
REASON(S):		

CIRCLE: WELL CHILD CARE/CLINIC SERVICES VISION DENTAL SPECIALTY (TYPE:_____) HOSPITAL: _____

*NAME:	# OF VISITS	DATE LAST SEEN:
*ADDRESS:		*TELEPHONE: ( ) *FAX: ( )
REASON(S):		

CIRCLE: WELL CHILD CARE/CLINIC SERVICES VISION DENTAL SPECIALTY (TYPE:_____) HOSPITAL: _____

*NAME:	# OF VISITS	DATE LAST SEEN:
*ADDRESS:		*TELEPHONE:( ) *FAX: ( )
REASON(S):		

E. What is happening now for your child?

1. What type(s) of equipment is currently used by your child? (Ö accordingly and complete)

	Wheelchair: Who provides/pays?		Walker:Who provides/pays?
	Splints/AFOs: Who provides/pays?		Eye Glasses:Who provides/pays?
	Adaptive Seating:Who provides/pays?		Hearing Aids:Who provides/pays?
	Adaptive Bathing:Who provides/pays?		Braces:Who provides/pays?
	Feeding Aids:Who provides/pays?		Assistive Communication Device(s): Who provides/pays?
	Other:		Other:

2. What medical, health equipment or supplies are routinely used by your child? (Ö accordingly and complete)

	Apnea Monitor		Oxygen
	Prescription Drugs		Feeding Tube
	Ventilator (dependent)		Other:

3. Current Medications (specify type, route and purpose) used by your child

Medication	Route (tube, mouth)	Purpose

E. What is happening now for your child? (continued)

4. Child's special diet: Yes_____ No_____ Type_____

Who provides/pays? _____

F. Developmental Milestones

FEEDING SKILLS					
	Formula/Breast fed only		Needs to be fed		Sucks/Chews on crackers
	Eats soft foods only		Holds own bottle		Needs assistance with eating
	Finger Feeds		Eats solid foods		Uses cup independently
	Feeds self w/spoon		Feeds self w/fork		Other:

Comment:

Is this an area of concern? NO YES: _____

FINE MOTOR SKILLS					
	Reaches for objects		Plays with toys, one hand		Plays with toys, both hands
	Claps hands, plays patty cake		Puts toys into containers		Picks up small objects
	Stacks block		Scribbles with crayon		Other:

Comment:

Is this an area of concern? NO YES: _____

GROSS MOTOR, MOBILITY					
	Head needs support		Holds head steady		Rolls Over
	Sits with Support		Sits Independently		Pulls to standing
	Crawls on hands and knees		Cruises holding on to things		walks with assistance
	Walks independently		Can climb stairs		Other:

Comment:

Is this an area of concern? NO YES: _____

Child's Name: _____ Date of Birth: _____ Date: _____

COMMUNICATION SKILLS					
	Eyegaze (familiar face/voice)		Smiles		Grunts
	Points		Babbles, no words yet		Uses single words/phrases
	Talks in sentences		Speaks clearly		Other:

Comment:

Is this an area of concern? NO YES: _____

SELF HELP OR ADAPTIVE SKILLS					
	Needs to be dressed		Wears diapers		Removes socks, shoes
	Cooperates in dressing		Toilet training in process		Dresses Independently
	Fully toilet trained		Other:		Other:

Comment:

Is this an area of concern? NO YES: _____

SOCIAL SKILLS					
	Smiles		Expresses comfort/discomfort		Responds to primary caregiver
	Laughs		Shows affection to familiar people		Shows different emotions
	Anxious when separated from caregiver		Interest in peers		Other:

Comment:

Is this an area of concern? NO YES: _____

COGNITIVE SKILLS					
	Looks to floor when something falls		Attains completely hidden object		Imitates body action on a doll
	Uses a stick to try to attain an object		Matches two sets of objects by item		Assembles three –piece body puzzle
	Understands concept of one		Matches four shapes		Other:

Comment:

Is this an area of concern? NO YES: _____

G. Pregnancy, Birth and General Health History

Is there anything important about your pregnancy with your child, or his/her birth or early health history that will be helpful to us in determining your child's eligibility or in planning services together?

1. Pregnancy (Ö accordingly)

a. Child was adopted Age at adoption: _____

b. Normal pregnancy reported

c. What month of the pregnancy did you start to see a medical provider?_____

Did you have regular medical care during this pregnancy? _____ YES _____ NO

d. During the pregnancy with this child, were any of the following present? (√ accordingly)

	Anemia		Flu		Prescription Drugs
	Bleeding		Vomiting		Non-Prescription Drugs
	Heart Disease		Toxemia		Alcohol/Drugs
	German measles		Kidney disease		Threatened miscarriage
	Virus:(type)		Measles		Early contractions
	Elevated blood pressure		Injury		Early bed rest
	Diabetes		Pre-eclampsia		Swollen ankles
	Other illness: (type:)		Other illness: (type:)		Smoking

COMMENTS:

_____

_____

_____

1. Pregnancy (Ö accordingly) (continued)

e. Type of delivery: (√ accordingly)

	Vaginal delivery		Breech delivery		Multiple Birth
	Caesarean delivery		Premature delivery		Other:

Comment:

f. Was any anesthesia used during childbirth? _____ No _____ Yes: Type: _____

g. Length of Labor: _____ hours

h. Were there any problems/complications during delivery? 1) for the mother:_____ No _____ Yes: What?_____

2) for the child: _____ No _____ Yes: What?_____

i. Were there any problems/complications after delivery? 1) for the mother:_____ No _____ Yes: What?_____

2) for the child: _____ No _____ Yes: What? _____

j. Weight gain during pregnancy: _____

2. Newborn Status

a. Check (√) any of the following which may apply.

	Healthy, no problems		Breathing problems		Ventilator (how long:)
	Jaundice		Delayed crying		Irregular heart beat
	Low birth weight		Seizures		Cord around neck
	Other:				

b. Newborn Information

Child's Birth Weight	**Birth Length**	**APGAR Scores**		
Grams/pounds	cm/inches	@ 1 minute:	@ 5 minutes:	@ 10 minutes:

c. Where was your child born? _____
Hospital Name/City/State

d. Did your child go home with you? _____ Yes _____ No

e. Length of Hospital Stay: Child: _____ days Mother: _____ days

f. Was your child transferred to another hospital? _____ No _____ Yes: Which hospital? _____
Hospital Name/City/State

g. How has your child's general health been since birth? (√ accordingly)

	Healthy, no problems		Surgery(s)		Vision problems:
	Sleeping problems		Feeding problems		Hearing problems:
	Repeated hospitalizations		Vomiting problems		Other:

Comments:

*Indicates information to be entered and stored electronically at the System Point of Entry

Note below any additional information including hospital discharge summary or reports provided during this interview:

H. The family needs information or asked questions about the following:

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
SECTION OF SPECIAL EDUCATION PROGRAM DEVELOPMENT

DETERMINATION OF NEED FOR EDUCATIONAL SURROGATE APPOINTMENT

DESE USE ONLY
Approved_____
Disapproved_____
Comments_____

NOTE: TO BE COMPLETED BY LOCAL EDUCATION AGENCY (Complete all items)

STUDENT INFORMATION

Name_____

Social Security Number _____ Date of Birth_____

Residential Facility_____

Contact Person/Title_____

Street_____

City_____ State_____ Zip_____

Phone Number_____

REFERRING DISTRICT

District Name_____

Contact Person_____

Title_____

Phone Number_____

SCHOOL ATTENDING

Name of District_____

Street_____

City _____ State_____ Zip_____

Phone Number_____

CASEMANAGER INFORMATION

Name_____

Agency Name_____

Street_____

City_____ State _____ Zip_____

Phone Number_____

If assignment of specific Educational Surrogate is preferred, indicate name of surrogate below:

_____

Please ✓ as appropriate.

1. The student's educational status:
   ____ the student has been referred for a special education evaluation.
   ____ the student receives special education and related services.
2. The district has determined, after reasonable efforts, that:
   ____ parent(s) cannot be identified.
   ____ whereabouts of parent(s) are unknown.
   ____ Other: _____
3. The student is in custody of:
   ____ DFS
   ____ DYS
   ____ Family Court
   ____ DMH
4. Court papers/documentation appointing guardianship are:
   ____ maintained by the district in the student's file.
   ____ not maintained by the district but have been reviewed by district personnel.
5. The student resides with
   ____ Parent/guardian
   ____ Foster parent
   ____ Other: _____

This information submitted herein is true and complete to the best of my knowledge.
Submitted this _____ day of _____, 20_____.

_____ _____
Signature Date

RETURN TO
Keep a copy for your records

Catherine Leiweke, Educational Surrogate Program
Department of Elementary and Secondary Education
Special Education Compliance
P.O. Box 480, Jefferson City, MO 65102
Phone #: 573-526-7605 Fax #: 573-526-5946

Missouri First steps EARLY INTERVENTION

Early Intervention Record

Access Log

Date of Access	Name/Title	Agency/Organization	Purpose of Review

HEALTH SUMMARY
Missouri FIRST STEPS Early Intervention System

Please complete this form to provide essential information from your perspective as this child's primary medical provider. Your participation is encouraged in order to ensure that appropriate medical information is available to assist in eligibility determination and service planning if the child is determined eligible. If you have questions, please contact the First Steps Intake Coordinator named on the cover letter. Your signature below indicates the accuracy and completeness of the information provided on this Summary. Thank you!

Initial Health Summary ***Health Summary Update***

IDENTIFYING INFORMATION

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

MEDICAL INFORMATION (For Initial Health Summary Only)

Reason(s) for Referral: _____

Birth Place: _____ Birth Weight: _____ grams _____ lbs/oz Gestational Age: _____

Length of Hospital Stay: _____

CURRENT HEALTH STATUS

Present concerns/diagnosis*/illnesses: (*ICD-9 CODE: _____) _____

Hospitalizations/Surgeries: _____

Current Medications: _____

Medical Precautions: _____

Immunizations are up to date: ? YES ? NO Date you last saw this child:_____

Physical Status: _____

Vision Status: _____ Hearing Status: _____ Developmental Status: _____

Date Screened/Tested: _____ Date Screened/ Tested:_____ Date Screened/ Tested: _____

Results: _____ Results: _____ Results: _____

Other Referrals Made: _____

ADDITIONAL COMMENTS. Attach additional pages if necessary.

Signature: _____ ***Date:*** _____ ***Name:*** _____

Primary Care Provider or Designated Representative

PCP#_____ Address: _____

Telephone:_____ FAX: _____

March 03

Getting To Know Our Child

Child's Name: _____Date of Birth: _____ Date: _____

1. What s/he really likes (to do, to play with, to calm down with, etc.):

2. I am most pleased for my child when:

3. What puzzles or worries me about my child is:

4. My child lets me know what s/he wants by:

5. I want others to see when s/he:

6. Better times of the day/week for me and/or for my child are:

7. I'd like _____ to be with me at the assessment or have their ideas and questions included.

WHAT to look for:	"HOW TO'S" so it will be comfortable for my child and useful for my family and other providers (e.g., toys, activities, pace)

Getting to Know Our Child - Instructions

Purpose: This WorkSheet is designed to help early intervention providers prepare for evaluation/assessment services for either eligibility determination or ongoing assessments performed during a family's participation in the First Steps system on either a periodic or interperiodic basis. By providing information about the child's learning style, play behaviors and successful child management techniques, the family assist the provider to structure the assessment recognizing and incorporating these important considerations into the selection of instruments, location, time of day and approach.

Legal Basis: 34 CFR part 303, Section 303.322 Evaluation and Assessment and Section 303.323 Nondiscriminatory Procedure and Section 303.342 (c) Procedures for IFSP development, review, and evaluation.

Instructions: The family, with assistance as needed from the Intake/Service Coordinator, should provide responses to the questions by giving information that best describes their child and their observations and opinions. This Section helps the family to inform early intervention providers how their child lets them know when something is wrong, and offers the opportunity for the family to talk about their child's favorite activities, attention span, and the best time for their child to be assessed. In addition to providing responses to these questions, the family should be encouraged to provide any additional information that they feel would be beneficial during the assessment and that will make this meaningful and useful for them and other providers. The provider will want to learn from the family about the specific ways that their child plays, needs positioning, or how to keep s/he engaged.

Application: This WorkSheet should be reviewed with the family prior to any formal assessment activities, and revised accordingly. Preparing for the assessment is an important step in the process for both the family and providers. The Intake/Service Coordinator should assist the family in completing this form and/or they can complete it on their own. The family's responses to this WorkSheet help us to know what specific questions the family has, and how to structure the assessment process to address these questions. This WorkSheet is shared with the provider(s) beforehand with a signed Release of Information form obtained prior to release.

1. What s/he really likes (to do, to play with, to calm down with, etc.):
Assessment activities should be conducted recognizing the child's pace, play preferences and toys. The family should identify what the child currently likes to do in play, what frustrates them, how they best learn, and how they are best comforted. Utilizing this information, the provider can enhance the assessment process by maximizing the child's performance through familiar settings and toys.

2. I am most pleased for my child when:
Each family will have a particular story or example of when their child is successful. Sometimes it is succeeding with a development skill, other times when they can communicate to someone that they don't see regularly and be understood. It may also be a routine daily activity – such as bathing – when the child enjoys the bath experience. For some families, their response to this question may be a report such as 'when my child has fewer seizures during the day."

3. What puzzles or worries me about my child is:
In response to this question, families should be encouraged to ask questions that may be troubling to them. These issues should be considered in the assessment process.

4. My child lets me know what s/he wants by:
How does the child communicate his/her needs to their parents and other family members? Cues such as eye gazing, pointing, grunting, specific cries or body posture can assist the provider to conduct the assessment in a way so as to incorporate these behaviors.

5. I want others to see when s/he:
Sometimes children don't demonstrate their skills to others, due perhaps to stranger anxiety, being in a different environment or the time of day. It is important for these skills to be observed by the provider, and for the family to be able to ask questions about specific skills, quality, intention, etc. Families may have questions about how their child moves to plays and should be able to use the assessment process to have these questions addressed.

6. Better times of the day/week for me and/or for my child are:
In addition to providing the assessment services in the natural environment of the child and family, it is important to conduct this activity when the child is fresh and alert. Working with the family, identify the optimal time of day and week to schedule assessment services.

7. I'd like _____ to be with me at the assessment or have their ideas and questions included.
If the family would like someone to observe the assessment, they should indicate who this is and discuss with the provider how this participation will be structured so as to contribute positively to the assessment process. Other times, a significant family member can't participate but may have questions or concerns. Incorporate these into the overall assessment process as well.

WHAT to look for:	"HOW TO'S" so it will be comfortable for my child and useful for my family and other providers (e.g., toys, activities, pace)
Use this section to summarize what to look for during this assessment based upon family concerns, questions and their ideas. Make certain that these are incorporated into the assessment process and verbally reported/discussed with the family during and after the assessment, and reflected in the written summary of the assessment afterward.	Use this section to discuss the time of day, location and how the child's typical routine (including favorite toys and activities) will be incorporated into the assessment process. Discuss positioning needs, pacing and other related issues that will ensure that this assessment is productive and comfortable for all.

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Authorization Form – Evaluation/Assessment/Teaming

Missouri First steps EARLY INTERVENTION

Child's Name:_____D.O.B. _____

Provider(s) Information:

Service Provider(s)/Billing Entity

Provider Name:_____ Agency / Independent

Agency Name: _____

Early Intervention Service: _____ Location: _____

Provider Name:_____ Agency / Independent

Agency Name: _____

Early Intervention Service: _____ Location: _____

Provider Name:_____ Agency / Independent

Agency Name: _____

Early Intervention Service: _____ Location: _____

Provider Name:_____ Agency / Independent

Agency Name: _____

Early Intervention Service: _____ Location: _____

Start Date of Service_____ End Date of Service: _____

Number of Minutes needed: _____

- ☐ Evaluation/Assessment/Structured Observation – Eligibility
- ☐ Evaluation/Assessment/Structured Observation –IFSP Planning
- ☐ Transition Meeting
- ☐ Eligibility Team Meeting
- ☐ IFSP Team Meeting

Requested by:_____ Date: _____

Data Entry by:_____ Date: _____

March 03

AUTHORIZATION FORM INSTRUCTIONS

***Purpose*:** This form is used by System Point of Entry [SPOE] personnel and on-going service coordinators to authorize early intervention services NOT included on a child's Individualized Family Service Plan [IFSP]. The services include all teaming, evaluation, assessment and structured observation activity. The form is generally faxed to the SPOE, which is responsible for data entry and submission to the Central Finance Office.

Child's name: Should be the legal name of the child.

DOB: Child's date of birth

Provider Information: Please complete this section carefully. This should tell the SPOE which provider is performing the service and who should be paid. Care should be taken if a provider has more than one payment arrangement within the system. Indicate if the person is with an agency or independent and if with an agency the agency name. Multiple providers can be listed on one form ONLY if they are being authorized for the same activity and same amount of time for the activity.

Early Intervention Service: Please select from the following list:

Assistive Technology Device	Nursing Services	Social Work/Counseling
Audiology	Nutrition Services	Services
Health Services	Occupational Therapy	Special
Interpreter services (bilingual)	Physical Therapy	Instruction/Developmental
Interpreter services (sign)	Psychological Service	Therapy
Medical Services	Coordination	Speech Language Pathology
	Service Coordination	Vision Services

Location: Use Home; Other Family Location; Community Setting; or Special Purpose Center or Clinic

Start date: Should represent a forward date and may be in advance of the actual planned event to allow the authorization to occur even if re-scheduling is necessary.

End date: No more then 30 days unless there are extenuating circumstances that are noted in the comments field. Can not be a date past current IFSP end date.

Number of Minutes needed: This is intended to be the maximum duration of the authorization. Typical authorizations for these activities range from 60 to 120 minutes in duration.

Check Box: Please check the service activity covered by this authorization form. Note: IFSP team meeting includes: initial, annual, 6-month review, periodic review meetings. Separate authorization forms will be used for different activities. IEP meetings held by the local district for children transitioning to Part B (ECSE) are not paid for by Part C and cannot be authorized with this form. Transition meeting should only be used for the required meeting conducted by the Part C system at age 2 years 6 months.

Assessment Reporting Guidelines

Assessment Reports

1. Content of the report should reflect the purpose of the evaluation or assessment. For example, the evaluation was conducted to help determine eligibility, whereas the assessment was conducted to assist in IFSP planning.

2. Reports must be written with sensitivity because they will be available to family members. This does not mean that issues should be ignored but that the conclusions should be described, qualified, and supported by the information that was obtained.

3. Personal comments are inappropriate.

4. In general, a written report should:
   - Be accurate, clear, objective, and detailed
   - Be free of jargon and terms that are subject to misinterpretation
   - Be readable by families and other professionals
   - Contain content that reflects the function for which it is intended to be used
   - Function as a means to communicate with other team members and professionals, including family members, specifying the best estimation of a child's abilities at a given point
   - Serve as a record against which later performance can be compared.

Reporting Data

How to report data from evaluation and assessment activities

- The report should be *clearly stated* and *match the purpose* of the conducted activities. For example, an eligibility report will look different than an assessment report because different procedures and tools were used.
- Although there are numerous formats that exist, some types of information are important to include.

The following format provides the opportunity for the organization of reporting evaluation /assessment information.

SAMPLE TEMPLATE
Evaluation/Assessment Report

1. **Identifying information**
   - Name, date of birth, date, chronological age, place of evaluation, evaluator(s).

2. **Reason for referral**
   - Record who made the referral, the reasons for the referral, and the areas of concern.

3. **Background information**
   a. **Developmental information –** significant developmental information as reported by the family or referral source.
   b. **Health status based on review of pertinent records and medical history –** summarize pertinent records related to the child's health status and medical history. If records were not available, please note at the time.
   c. **Other evaluations and services –** note the type and dates of evaluations and services, which have been provided to the child. Record any disability or medical condition, which has been identified previously. Report the services that have been provided to the family if they are related to enhancing the development of the child.

4. **Discuss questions to be addressed in the evaluation or assessment**
   a. List the questions to be addressed during the evaluation or assessment activity. These questions may have been generated by the family members, the Intake or Service Coordinator, or others who have an interest in the child's development.

   Examples
   This (evaluation or assessment) is being conducted to answer the following questions:

   - Is _____ eligible for early intervention services?
   - Does _____ have a disability or developmental delay?
   - What are _____'s current levels of development and daily routines?
   - What are _____'s individual strengths and needs?
   - What are the possible strategies for _____'s success in daily routines?

5. **Discuss individual child strengths and developmental status**
   - In family friendly language, list the tool(s) that were used and indicate the purpose of the tool.

- Include information from formal tests, informal assessments, clinical observation, and family members.
- Information may be across multiple domains or domain specific, depending upon the individual(s) who is/are writing the report.
- Record observations and information from all members including the family and report what the child can do or what he is beginning to do.
- If the purpose of the report is evaluation of eligibility, the information in this section should assist in determining if the child is a child with a disability or developmental delay and if he/she is eligible for early intervention (EI) services. Typically, the section will contain scores. However, remember that scores should not stand-alone. Descriptive information should accompany scores.
- If the purpose of the report is assessment for IFSP planning/intervention planning, this section should contain information that will assist the IFSP team in developing outcomes. For example, the information should describe what the child is beginning to do, areas of need, and what strategies might be appropriate to target areas of need.

6. Information regarding daily routines, if obtained

- This area may include additional information on the child's daily routines that was provided by the family during the pre-evaluation or family assessment phase.
- This information should NOT be a duplication of information in the adaptive areas of a report.

7. Summary and recommendations

- This section should summarize the information within the context of the report. Discussing the child's strengths and needs based upon results. The report should indicate if services are warranted. Specific recommendations related to frequency, intensity of services are not appropriate at this time and should not appear in this report.
- If the purpose of the activity was assessment for IFSP planning, the professional should provide strategies or activities that could be incorporated into the IFSP to support the process of developing child/family outcomes.

Communicating Findings

The following points should be considered in discussing evaluation and assessment information with families:

- Discuss information with families as quickly as possible after the child's needs are suspected or formally identified.
- Use the primary language and communication style of the family, and ensure that terminology is clear and understandable.
- Set aside sufficient time for families and professionals to present information, ask questions, and provide emotional support.
- Provide families with an opportunity to decide on the appropriate family members and professional to include in assessment conferences. Scheduling should allow for the participation of these designated members.
- Honor family preferences for the amount of information that can be absorbed in one meeting. Continuing family-professional feedback sessions are sometimes necessary.
- Provide complete, unbiased information to families about their child's strengths and needs. Remember to discuss family needs and look for hope and encouragement.
- Oral reports should always be followed by written reports.
- Professionals must respect issues of confidentiality and parental access. Families need to have access to the same information as the other individuals who are conducting and coordinating the evaluation and assessment.

ELIGIBILITY CRITERIA (34 CFR 303.300)

Children who are eligible for early intervention services are children between the ages of birth and 36 months who have been determined by a multidisciplinary team composed of at least two different disciplines as having:

A. A diagnosed physical or mental condition associated with developmental disabilities or has a high probability of resulting in a developmental delay or disability.

STATE DEFINITION OF DIAGNOSED CONDITIONS

The State of Missouri has adopted the following conditions to meet the definition of "diagnosed physical or mental condition that has a high probability of resulting in a developmental delay":

1. Conditions diagnosed at birth or within 30 days post birth (newborn conditions)
   a. Very Low Birth Weight (VLBW; less than 1,500 grams) with one or more conditions:
      --Apgar of 6 or less at 5 minutes
      --Intracranial bleeds (Grade II, III, or IV)
      --Ventilator dependent for 72 hours or more
      --Asphyxiation

OR:

2. Conditions Diagnosed (Neonatal/Infant/Toddler Conditions)
   a. Genetic conditions known to be associated with mental retardation or developmental disabilities including but not limited to:
      --Down Syndrome
      --Cri-du-Chat Syndrome
      --Klinefelter's Syndrome
      --Trisomy 18 Syndrome (Edward's)
      --Turner's Syndrome
      --Trisomy 13 Syndrome (Patau's)
      --Triple X Syndrome
      --Fragile X Syndrome
      --Prader Willi
      --Pierre Robin

OR:

   b. Additional conditions known to be associated with mental retardation or developmental disabilities including but not limited to:
      --Hypoxic Ischemic Encephalopathy (HIE) (36 weeks gestation or more)
      --Cranio-facial anomalies (i.e, cleft palate, etc.)
      --Epilepsy/ Seizure Disorder
      --Spina Bifida
      --Blindness, including visual impairments
      --Macro/Microcephalus, including Hydrocephalus
      --Deafness, including hearing impairments
      --Fetal Alcohol Syndrome
      --Cyanotic Congenital Heart Disease
      --PKU
      --Cerebral Palsy
      --Viruses/bacteria (Herpes, syphilis, cytomegalovirus, toxoplasmosis, and rubella)
      --Acquired Immune Deficiency Syndrome (AIDS)
      --Autism Spectrum Disorders

OR:

3. Other conditions known to be associated with mental retardation or developmental disabilities to be considered for eligibility must be based upon informed clinical opinion by Board certificated neonatologists, pediatricians, geneticists, and/or pediatric neurologists. These physicians may refer a child by indicating the specific condition and documenting the potential impact of the condition in any of the five developmental areas.

OR:

B. Developmental Delay (34 CFR 303.11):

The child, as measured by appropriate diagnostic measures and procedures emphasizing the use of informed clinical opinion, is functioning at half the developmental level that would be expected for a child considered to be developing within normal limits and of equal age. In the case of infants born prematurely, the adjusted chronological age should be assigned for a period of up to 24 months and is determined by deducting one-half of the prematurity from the child's chronological age. The delay must be identified in one or more of the following areas:

a. cognitive development;
b. communication development;
c. adaptive development;
d. physical development, including vision and hearing;
e. social or emotional development.

FIRST STEPS Early Intervention System
Eligibility Determination Documentation

SPOE:_____Date: _____

*Intake Coordinator:_____

MC+ Managed Care Case Manager: _____

*Child's Name: _____ *Date of Birth: _____

*Parent/Guardian Name: _____ *Date of Referral: _____

Eligibility determination activities pursuant to Sections 303.300 and 303.322 of 34 C.F.R. Part 303 were conducted for this child and resulted in the findings as stated below.

1. * Statement of Concern/Reason for Referral _____ Date Completed

2. Family Members' Statement of Concern about Referral _____Date Completed

3. Combined Enrollment Application/Social History Interview _____Date Completed

4. Review of Pertinent Records including vision, hearing and developmental screening _____Date Completed

*Indicates information entered and stored electronically at the System Point of Entry

5. Intake Coordinator Observation _____ Date Completed

IS THERE SUFFICIENT INFORMATION AVAILABLE IN ITEMS 1-5 TO MAKE AN ELIGIBILITY DETERMINATION?
_____ Yes (Proceed to Section 7) _____ No (Continue with Section 6) Remarks:

6. Formal Evaluation/Assessment/Structural Observation Information

Domain	Method/Instrument Used	Clinician Name/ Date Administered	Statement of Child's Level of Performance (Age equivalency, if possible)
Cognition:			
Physical Dev.			
Communication			
Social/Emotional			
Adaptive Dev.			

7. _____ Determined Eligible

*7a. _____ DOCUMENTATION OF ELIGIBILITY THROUGH PHYSICIAN CONFIRMATION OF CONDITIONS DIAGNOSED AT BIRTH OR WITHIN 30 DAYS POST BIRTH (NEWBORN CONDITIONS) (Attach NICU Referral/Physician Statement)

Very Low Birth Weight (VLBW: less than 1,500 grams) **with** one or more of the following conditions:
___Apgar of 6 or less at 5 minutes
___Intracranial bleeds (Grade II, III, or IV)
___Ventilator dependent for 72 hours or more
___Asphyxiation

Diagnosis:_____ ICD-9 CODE: _____

OR:

*7b. _____ DOCUMENTATION THROUGH PHYSICIAN CONFIRMATION OF MEDICAL DIAGNOSIS:

Medical Diagnosis (Maintain physician documentation of eligibility for conditions outlined in A(3) of the eligibility criteria which may include a medical report or Initial Health Summary in the child's Early Intervention Record)

Diagnosis:_____ ICD-9 CODE: _____

OR:

*7c. _____ DOCUMENTATION OF ELIGIBILITY THROUGH CONFIRMATION OF DEVELOPMENTAL DELAY: ICD-9 CODE: _____

____ Functioning at half the developmental level in at least one (1) developmental domain that would be expected for a child considered to be developing within normal limits and of equal age List area(s)_____

OR

____ Decision made through informed clinical opinion. (Rationale must be documented below)

Rationale:

_____

_____

_____

_____

*8. _____ Determined NOT Eligible

FIRST STEPS Early Intervention System
Eligibility Determination Documentation Instructions

SPOE:_____ Date: _____

*Intake Coordinator/Service Coordinator:_____

MC+ Managed Care Case Manager: _____

*Child's Name: _____ * Date of Birth:_____

*Parent/Guardian Name: _____ * Date of Referral: _____

Eligibility determination activities pursuant to Sections 303.300 and 303.322 of 34 C.F.R. Part 303 were conducted for this child and resulted in the findings as stated below.

This document provides a consolidated recording of those events, activities and source documents used to determine a child's eligibility for First Steps. The intent of the form is to guide the Intake Coordinator through the various approaches to the determination of eligibility beginning with the use of medical diagnosis and informed clinical opinion PRIOR to the administration of any assessments including formal testing or other diagnostic services. Depending upon the individual situation, not all sections of this form will be used. These sections should be marked with a N/A for "not applicable" and not left blank.
In completing this form, the Intake Coordinator is responsible for recording the specific information from the EI Record that is applicable to eligibility determination. The Intake Coordinator is responsible for ensuring that all requirements for eligibility determination are met. Once completed, this form is then used by the System Point of Entry (SPOE) for data entry purposes and is retained in the child's Early Intervention Record maintained at the System Point of Entry. A copy of the completed form should be provided to the family and available to other providers involved in the development of the IFSP or in ongoing service delivery.

1. * Statement of Concern/Reason for Referral

Eligibility determination begins at referral. The reason(s) for referral MAY determine eligibility, such as a diagnosis of Down syndrome (medical diagnosis). In the case of medical diagnosis, the physician documents the diagnosis. In the case of "other conditions," the physician must state that this condition is likely to cause or contribute to developmental delay or disability.

If the referral documents either established (medical diagnosis) or "other conditions," it should be documented in this section and the Intake Coordinator would go to page 3 to complete the eligibility documentation. All physician documentation must be signed and dated by the physician, or the physician's designated representative, and a copy must be maintained in the child's EI record.

If the reason for referral is due to a suspected developmental delay, record information about the area(s) of concern.

The reason(s) for referral also begin to identify the type(s) of EI professionals to be involved in the eligibility determination process, and/or the IFSP development activities.

2. Family Members' Statement of Concern about Referral

During the initial contact with families, the Intake Coordinator discusses the reason(s) and source of referral with the family. Does the family share these concerns? Do they have additional concerns? If so, what are these? This family report is recorded on the Combined Enrollment/Social History Form and is summarized in this section of the Eligibility Determination Documentation. If the family has no concerns about their child's development, this would be so stated in this section.

If the family agreed with the reason for referral, their statements would be reported in this section. If the family has <u>different</u> concerns from those presented by the referral source, these should also be reported also in this section.

DO NOT LEAVE THIS SECTION BLANK.

3. Combined Enrollment Application/Social History Interview

The comprehensive Combined Enrollment/Social History interview includes information that may assist in the determination of eligibility.

The Intake Coordinator must determine what information OF RELEVANCE TO ELIGIBILITY was obtained in the course of this interview.

Record a summary of the information <u>that pertains to eligibility</u>.

IF NOTHING IS NOTED IN THE INTERVIEW THAT CAN BE APPLIED TO ELIGIBILITY, THIS SECTION IS MARKED N/A.

4. Review of Pertinent Records including vision, hearing and developmental screening

During the intake activities, the family will identify a variety of sources of existing information that should be requested IF APPLICABLE to the eligibility determination or service delivery planning process. Existing information might include results of developmental assessments, checklists, or screening. Signed releases from the family should be completed for each information source. It is important to obtain all existing information that is relevant to the eligibility and/or service planning process and to avoid any duplication of screening or other activities needed to complete this step of the First Steps process.

In addition to requesting this information in writing, the Intake Coordinator could contact the information source by telephone and request the information verbally after that information source has received the signed release of information form. This should help to meet the 45-day timeline between referral and IFSP development. A signed copy of the original document should still be received from the source, but their verbal input may be documented by the Intake Coordinator in the child's EI Record. The Health Summary may be used to record information from the physician's office obtained via a telephone call, but the original signed document must still be obtained and filed in the EI Record. This section would include documentation of any medical evaluations performed and the application of this information upon eligibility determination.

Formal developmental screening is not a required step in the eligibility determination process. However, if general developmental information in all domains is not available about the child at referral, it would be best practice to have the child screened. Some resources for screening at the present time are Parents as Teachers, physicians, and Well Baby Clinic at county health departments. If the child has not had a comprehensive developmental screening within a reasonable period of time, or if the results of this screening are not available, the Intake Coordinator may assist the family to obtain this screening if needed.

Nutrition screening and or evaluation would be appropriate if there are nutrition concerns.

It may be appropriate for the SPOE to authorize the services of a nurse to review medical records and develop a nursing summary to help determine eligibility. This reduces the potential duplication of assessment or screening activity and ensures that all relevant medical information is used in the decision-making process and reflected in documentation.

DO NOT LEAVE THIS SECTION BLANK – USE N/A IF APPROPRIATE.

5. Intake Coordinator Observation

It may be appropriate for the Intake Coordinator to document observations made of the child while conducting a home visit, however this is not required in order to determine a child's eligibility for First Steps.
DO NOT LEAVE THIS SECTION BLANK – USE N/A IF APPROPRIATE.

IS THERE SUFFICIENT INFORMATION AVAILABLE IN ITEMS 1-5 TO MAKE AN ELIGIBILITY DETERMINATION? _____ Yes (Proceed to Section 7)
_____ No (Continue with Section 6)

Remarks: Complete this section to document whether or not the information gathered through the referral/intake process was sufficient to determine if the child's eligibility for First Steps. If sufficient information was obtained, eligibility can be determined. If the material collected is insufficient to determine eligibility, the Intake Coordinator will arrange for assessments/observations that are necessary to determine eligibility. These assessment results are summarized in Section 6.

6. Formal Evaluation/Assessment/Structured Observation Information

Domain	Method/Instrument Used	Clinician Name/ Date Administered	Statement of Child's Level of Performance (Age equivalency if possible)
Cognition			
Physical Dev.			
Communication			
Social/Emotional			
Adaptive Dev.			

For formal and informal assessments: Indicate the assessment instrument(s) used to evaluate the child. Indicate the name(s) of the individual who administered the test and the date of testing. Summarize the scores and age equivalency data.

For structured observations: Indicate the checklist or assessment instrument(s) used during the observation. List the name of the individual who conducted the observation. List the age equivalency data that was obtained during the process.

7. _____ Determined ELIGIBLE

IF ELIGIBLE, use the sections below to document which one of the three (3) types of eligibility have been documented and how this decision was made. Complete the information blanks as appropriate.

The order of the eligibility documentation reflects the easy identification and documentation, including data entry, of eligibility for First Steps. ICD-9 code detail has been added to ensure accuracy of the diagnosis and eligibility assignment. This code should be assigned by the Intake Coordinator and not the SPOE administration staff person responsible for data entry.

7a. _____ DOCUMENTATION OF ELIGIBILITY THROUGH PHYSICIAN CONFIRMATION OF CONDITIONS DIAGNOSED AT BIRTH OR WITHIN 30 DAYS POST BIRTH (NEWBORN CONDITIONS) (Attach NICU Referral/Physician Statement)

___ Very Low Birth Weight (VLBW: less than 1,500 grams) **with** one or more of the following conditions:
___Apgar of 6 or less at 5 minutes
___Intracranial bleeds (Grade II, III, or IV)
___Ventilator dependent for 72 hours or more
___Asphyxiation
Diagnosis_____ _____ ICD-9 CODE

Newborn conditions are conditions diagnosed at birth or within 30 days post birth. That means that the criteria listed has to be diagnosed at birth or within 30 days post birth, not that the child has to be referred to First Steps within 30 days post birth.

OR:

7b. _____ DOCUMENTATION THROUGH PHYSICIAN CONFIRMATION OF MEDICAL DIAGNOSIS: _____ ICD-9 CODE

___ Medical Diagnosis

OR:

7c. _____ DOCUMENTATION OF ELIGIBILITY THROUGH CONFIRMATION OF DEVELOPMENTAL DELAY: _____ ICD-9 CODE

___ Functioning at half the developmental level in at least one (1) developmental domain that would be expected for a child considered to be developing within normal limits and of equal age List Area(s)_____
OR
___ Decision made through informed clinical opinion
Rationale
_____
_____

In order to arrive at eligibility using informed clinical opinion, documentation must be thorough enough to support the decision. The ICD-9 code 315.9 may be used for developmental delay if no other ICD-9 code has been assigned.

8. _____ Determined NOT Eligible

If after reviewing and gathering all information, there was not sufficient evidence to determine the child eligible, indicate this here, and provide the parent with a Notice of Action – Ineligible.

Meeting Notification

Date:

Dear,

This is to confirm that a meeting for _____ has been scheduled for
(child's name)

_____at _____at _____.
(date) (time) (location)

The purpose of this meeting is to:

( ) Discuss referral to First Steps
( ) Develop Initial IFSP*
( ) Annual IFSP Meeting*
( ) Other:
( ) Eligibility Determination Meeting
( ) Review/revise IFSP Meeting*
( ) Transition Meeting*

The following individuals have been invited to attend this meeting: (individuals are listed by name with discipline)

We hope that you will share your observations, questions, concerns and priorities for your child and family during the meeting. You may also invite any additional individuals whom you would like to participate. If this time is not convenient or you need to reschedule for any reason, please call me at _____or write me at _____.
(phone number) (address)

Sincerely,

* Required by state regulations to provide written notification prior to the meeting.

First Steps Brochure Order Form

Brochure	Quantity
☐ First Steps General Informing Brochure	
☐ First Steps General Informing Brochure (Spanish Version)	
☐ First Steps Parental Rights Brochure (SPOE/Service Coordinator use only)	
☐ First Steps LICC Brochure (LICC use only)	

Name: _____

Agency: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____

Email Address: _____

Please indicate which area of implementation you are in:

☐ Phase 1 ☐ Phase 2 ☐ Phase 3

Please mail completed order form to:

Effective Practices
Attn: Lori Conner
P.O. Box 480
Jefferson City, MO 65102
(573) 751-0187
Or Fax: 573-526-5946 Or Email: lori.conner@dese.mo.gov

IFSP PLANNING

1. IFSP Planning Worksheet
2. IFSP Planning Instructions
3. "Identifying Typical Family Routines and Activities" Worksheet
4. "Indentifying Typical Family Routines and Activities" Instructions

IFSP Planning Worksheet

Child's Name: _____ Date of Birth: _____ Date: _____

IFSP Team Membership Selection by family and Service Coordinator, to identify team members who will be helpful in addressing child and family outcomes, issues and tasks. (Circle those to be invited**)

Family/Community:

· Parents
· Interpreters
· Respite, child care providers
· Advocates
· Ministry
· Parents as Teachers
· Inclusive Child Care Coordinator
· Early Childhood Program (e.g., preschool program, child care provider)
· Other family members, relatives, friends
· Community, civic, disability or parent groups
· Early Head Start/Head Start
· ECSE representative
· Legal representation
· Other:

Social Services:

· Social Worker
· DFS Case Worker
· Other private providers:

Early Intervention Providers:

· Developmental Specialist (Spec.Instr.)
· Special Education Teacher
· Special Instruction Practitioner
· Speech/Language Pathologist
· Mental Health Practitioner
· MO-SPIN for visual impairments,
· Project OutReach for hearing impairments
· First Steps Service Coordinator
· Nurse
· Occupational Therapist
· Physical Therapist
· Psychologist
· Nutritionist
· M-PACT
· Other:

Health Care Providers

· Primary care physician
· Private home health care
· Specialists/specialty centers
· Public health nursing
· Other:
· Other physician(s)
· Primary nurse
· Other hospital staff
· Community health services
· Personal care attendants
· Other:

Planning the IFSP Team Meeting: The family and Service Coordinator create an agenda for the IFSP Team Meeting.

1. Convenient times for family and other team members to attend:

2. Desired location of the meeting:

3. Who will lead the meeting?

4. Agenda for the meeting:

5. Approximate length of meeting time:

6. Preparation needed:

**Prompts prior written notification detailing date, location, time and purpose of the meeting as well as who is expected to attend.

March 03

Instructions for IFSP Planning Worksheet

Purpose: This is an opportunity for the family and intake/service coordinator to plan who will be at the IFSP meeting, where and when the meeting will be held, and what will be discussed.

Legal Basis: 30 CFR part 303, Section 303.342 (c) Accessibility and convenience of meetings and Section 303.343 participants in IFSP meeting and periodic reviews.

Instructions:
IFSP Team Membership Selection: The intake/service coordinator should discuss the variety of issues that may come up at the IFSP team meeting with the family. Circle all those individuals whom the family wishes to be considered as members of the IFSP team. In selecting who should be invited, keep in mind who may be helpful in addressing child and family outcomes, strategies, and activities. Families need to make sure that they have appropriate supports for themselves as well (like someone to take notes for them while they talk).

Planning the IFSP Team Meeting: Discuss with the family the time, location that will be convenient for them, who will lead the meeting and what needs to be discussed at the meeting. This formulates a reasonable agenda and will be helpful in determining an approximate length of time for the meeting so individuals invited and the family knows what amount of time to commit to the meeting. List any items that may need to be completed before the meeting (i.e. gathering additional assessment information beyond what was needed to determine eligibility). The family is assisted by the intake/service coordinator in reviewing the Provider Matrix and selecting providers for the IFSP Team who have the expertise and information related to concerns, priorities, and resources that they have identified.

Application: This Worksheet can be completed with the family by the intake/service coordinator before the initial IFSP, periodic reviews, and annual IFSP meetings. Completion of this Worksheet prompts the intake/service coordinator to issue written prior notification to all who have been invited to the IFSP meeting, including the family.

Child's Name: _____ Date of Birth: _____ Date: _____

IDENTIFYING TYPICAL FAMILY ROUTINES AND ACTIVITIES

1. What activities do you and your family like to do together?

2. Where do you and your child spend time?

Where would you like to spend more time?

3. What routines or activities in your home or community would you like your child or family to participate in?

4. Who are important people in your family's life?

5. Other Information:

Instructions for "Identifying Typical Family Routines and Activities" WorkSheet

Purpose:

This worksheet assists the IFSP team in identifying the settings in which the child and family are typically located. This worksheet can help to define strategies and activities that may assist in expanding access to these settings for an eligible child and can assist significantly in the IFSP planning. This worksheet provides the opportunity for a thoughtful discussion of what kinds of activities the family is currently involved in, what they would like to be doing, and how First Steps can effectively support the family.

Instructions:

The identification of outcomes, services and the location for provision of services in a Natural Environment begins with the discussion of where the child currently spends their day, followed by where the child would be without consideration of their developmental delay or disability, given the family's lifestyle, plans and other commitments. This may include, for example, typical events and activities that families are routinely engaged in such[1] as:

Family Routines including cooking, food shopping and caring for family pets and other animals
Parenting Routines such as bed and bath time
Child Routines including dressing, eating, brushing teeth
Literacy Activities such as looking at books, listening to stories, reading
Play Activities including drawing, lap games, playing with toys
Physical Play such as roughhousing, swimming, playing ball
Entertainment including dancing, singing, watching TV
Family Rituals including family talks, story telling, saying grace at meals, spiritual readings

Natural learning environments in the community include:
Family Excursions such as running errands, car or bus rides, weekend chores
Family Outings to include shopping, eating out, visiting friends and relatives
Play Activities such as outdoor playgrounds and indoor playlands
Community Activities including libraries, fairs and festivals
Recreational Activities such as horseback riding, swimming, sledding
Children's Attractions to include petting zoos, nature centers, pet stores
Art/Entertainment Activities such as children's theater, storytellers, music activities
Church/Religious Activities including Sunday school, nursery at church/synagogue, church services

[1] Adapted from Natural Learning Opportunities for Infants, Toddlers and Preschoolers (Dunst, Bruder, Trivette, Raab and McLean, 2000)

What activities do you and your family like to do together (Q1)? The family will be able to identify several activities that their family enjoys doing together and, share where they spend their time with their child (Q2) both within and outside of the family home. The family may be able to identify places or activities that they would like to spend more time, and why this is important to them and to their child.

Question 3 is very important. It is intended to describe activities or routines that the family is NOT currently involved in because of their child's special needs. The purpose of this question is to assist families in identifying community or neighborhood programs, services or facilities in which they might want to participate – but haven't, due to their child's developmental or health/medical needs. This helps to identify potential opportunities for early intervention and the need for resource development to expand community options beyond traditional disability locations.

Describe the supports and services that the family would need to have their child included in routines and activities that are typical for children without disabilities and their families. What activities are particularly difficult for the family to accomplish now? How can First Steps services support the family with respect to these challenges?

Question 4 helps the family to identify who is important to them now. How can First Steps support the family to engage and inform important people in their lives?

Other general information or comments may be recorded in Question 5.

Application: This worksheet is designed to be completed with the family prior to the initial and annual IFSP team meetings. The intake/service coordinator will assist the family to use this worksheet to guide a discussion about their routines and typical activities at the IFSP meeting and it may be used to assist in identifying the location for provision of services in Natural Environments. This worksheet should be shared with the other IFSP team members during the IFSP meeting.

IFSP

Complete IFSP Form and Form by Sections

1. Complete IFSP Form
2. IFSP Instructions for Completion
3. **IFSP Form by Section**
4. Section 1 – Child Information
5. Section 2 – Family Introduction
6. Section 4 – Child's Present Abilities and Strengths: Team Summary
7. Section 5 – Summary of Family Concerns, Priorities and Resources to Enhance the Development of Their Child
8. Section 6 – Family and Child Centered outcomes(s)
9. Section 7 – Early Intervention resources, Supports and Services
10. 7a – Assistive Technology Authorization – IFSP Meeting Date
11. 7b – Transportation Authorization
12. Section 8 – Natural Environments Justification
13. Section 9 – Other Services
14. Section 10 – Transition Checklist
15. Section 11 – IFSP Devleopment Team and Contributors
16. Section 12 – IFSP Review Documentation Worksheet

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

The Individualized Family Service Plan describes
how the First Steps early intervention system will assist each family in helping
their very young child with a disability or developmental delay to grow and develop.

Missouri First steps EARLY INTERVENTION

Section 1: CHILD INFORMATION

*Child's Name:_____*Nickname: _____*Gender: M F A

*Home Street/Address: _____*Mailing Address: _____

*City/Town: _____MO, Zip: _____ *County: _____

*Date of Birth: _____ Chronological Age: _____Adjusted Age: _____

*Reason for Eligibility: _____*Native Language : _____

*School District:_____*SSN#: _____ *Medicaid #: _____

DIRECTIONS TO CHILD'S HOME

***MEETING DATE INFORMATION:**

IFSP Meeting Type:

☐ Interim ☐ Initial ☐ 6 Month Review ☐ Interperiodic Review ☐ Annual ☐ Transition

Meeting Date: ____/ ____/ ____

IFSP Start Date: _____/_____/_____ IFSP End Date: _____/_____/____

Child's Name: _____ Date: _____

Section 2: FAMILY INFORMATION

*Primary Contact: _____

*Relationship to child: _____

*Mailing Address: _____

*City/Town: _____*State: _____*Zip: _____

*Home/Street Address: _____

*Day Phone: _____ (h___ w___)
*Evening Phone: _____ (h___ w___)
*Best time to call: _____
E-mail: _____
Other way to contact: _____
*Native language:_____
*Interpreter Needed? Yes No

OTHER CONTACT INFORMATION:
*Name: _____

*Relationship to child: _____

*Mailing Address: _____

*City/Town: _____*State: _____*Zip: _____
*Home/Street Address:_____
*Day Phone: _____ (h___ w___)
*Evening Phone: _____ (h___ w___)
*Best time to call: _____
E-mail: _____

Section 3. SERVICE COORDINATOR CONTACT INFORMATION

*Name: _____

*Agency: _____

*Work Telephone: _____

*Cell Phone: _____

*Best time to call: _____

*FAX: _____

*E-mail address: _____

Mailing Address: _____

City/Town: _____

*State: _____ *Zip: _____

*MC+/Plan Contact Person : _____

*Telephone:_____ *FAX Number: _____

*Physician: _____

*Address: _____

*City/Town: _____, State: _____ Zip: _____

Telephone: _____ FAX:_____

E-mail: _____

Child's Name: _____ Date: _____

Section 4: CHILD'S PRESENT ABILITIES AND STRENGTHS: TEAM SUMMARY.

WHAT MY CHILD CAN DO NOW - INTERESTS, MOTIVATORS, NEW SKILLS, THINGS TO CELEBRATE, WHAT MY CHILD IS READY TO DO, WHAT'S WORKING WELL. Make sure that all developmental domains are included. Describe in an integrated, functional manner how this child: does things for him/herself (Adaptive/Self Help Skills); how s/he problem solves and plays (Cognition); how s/he uses hands, oral motor skills, how s/he moves around (Physical Skills); how s/he indicates understanding, wants, and needs (Communication Skills); and how s/he shows feelings, copes with frustration or stimulation, and gets along with others (Social/Emotional Skills).

Adaptive Self Help:

Cognition:

Physical:

Communication:

Social/Emotional:

Vision / Hearing:

Health/Physical/Nutrition Status:

Other Strengths/Concerns including relevant information (medical diagnosis, birth history, health status, sensory issues, etc.) or other concerns, which might affect service delivery.

Child's Name: _____ Date: _____

Section 5. SUMMARY OF FAMILY CONCERNS, PRIORITIES AND RESOURCES TO ENHANCE THE DEVELOPMENT OF THEIR CHILD

Family declined consent to complete an assessment of family concerns, priorities and resources: Yes No (If "yes" leave this section blank, If "no" this section must be completed.)

I have questions about or want help for my child in the following areas:

- ☐ Moving around (crawling, scooting, rolling, walking)
- ☐ Ability to maintain positions for play
- ☐ Talking and listening
- ☐ Thinking, learning, playing with toys
- ☐ Feeding, eating, nutrition
- ☐ Having fun with other children; getting along
- ☐ Behaviors and feelings
- ☐ Toileting; getting dressed; bedtime; other daily routines
- ☐ Helping my child calm down, quiet down
- ☐ Pain or discomfort
- ☐ Special health care needs
- ☐ Seeing or hearing
- ☐ Other: _____

I would like to share the following concerns and priorities for myself, other family members, or my child:

- ☐ Finding or working with doctors or other specialists
- ☐ How different services work or how they could work better for my family
- ☐ Planning for the future; what to expect
- ☐ Parenting skills
- ☐ People who can help me at home or care for my child so I/we can have a break; respite or child care
- ☐ Housing, clothing, jobs, food, or telephone
- ☐ Information on my child's special needs, and what it means
- ☐ Ideas for brothers, sisters, friends, extended family
- ☐ Money for extra costs of my child's special needs
- ☐ Linking with a parent network to meet other families or share information
- ☐ Other: _____

FAMILY'S CONCERNS ABOUT THEIR CHILD

PRIORITIES OF THE FAMILY (Select from items checked to the left)

STRENGTHS, RESOURCES THAT OUR FAMILY HAS TO MEET OUR CHILD'S NEEDS

Child's Name: _____ Date: _____

Section 6. FAMILY AND CHILD CENTERED OUTCOME(S) **This page should be duplicated as needed**

Outcome # _____:

Optional: Strategies and Activities: (Summarize ideas for addressing the outcome within the child and family's naturally occurring routines and environments using people and materials that are available there. This is not a listing of early intervention services)

When will we as a team measure progress towards this outcome? (timeline)

How will we, as a team, measure progress towards this outcome? (procedure)

Our team will be satisfied we are finished with this outcome when: (criteria)

Child's Name: _____ Date: _____

Section 7. *EARLY INTERVENTION RESOURCES, SUPPORTS AND SERVICES This entire page is part of electronic record.

Column A	Col. B	Column C	Column D	Col. E	Col. F	Col. G	Col. H	Col. I	Col. J	Col. K	Col. L
Outcome(s) #	Early Intervention Service(s)	Start Date	End Date	Provider(s) Name	Method (see below)	Ind. Or Group	Location (see below)	Frequency	Intensity	Funding Source	Initial (I) Addition (A) Revision (R)
#											
#											
#											
#											

1) Column F, Method Code: 1 = Consultation/Facilitation with Others; 2 = Family Education/Training/Support; 3 = Direct Child Service
2) Column H, Location Code: 1 = Home; 2 = Other Family Location; 3 = Community Setting; 4 = Special Purpose Center or Clinic

Primary Setting for this IFSP: (circle) special purpose facility - community setting - home - hospital - residential facility - service provider location - other setting

Child's Name_____ Date:_____

***Section 7a. Assistive Technology Authorization – IFSP Meeting Date:_____**

IFSP Outcome #	Start Date	End Date	Provider	HCPCS Code	Description of Item	• Purchase • Rental • Repair	Quantity	Price	Remarks (Optional)

***Section 7b. Transportation Authorization**

IFSP Outcome #	Start Date	End Date	Provider	Frequency	Maximum miles per trip

Child's Name: _____ Date: _____

Section 8: Natural Environments Justification

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Child's Name _____ Date: _____

Section 9: * Other Services **This entire section is part of the electronic record.**

Service	Family or Child Service	Responsible Individual	Fund Source
	family / child		
	family / child		
	family / child		
	family / child		
	family / child		

Child's Name: _____ Date: _____

Section 10: Transition Checklist

Transition Activities into, within and from First Steps: Identification of activities and responsible individuals to assist the family and child with transitions include:	Specific Transition Issue	Who is responsible
Transition into and within: (Optional)		
1. Transition from hospital, neonatal intensive care unit to home, and into early intervention services to ensure that no disruption occurs in necessary services		
2. Family related changes that may affect IFSP service delivery i.e., employment, birth or adoption of sibling, medical needs of other family members)		
3. Child related changes that may affect IFSP service delivery (i.e., hospitalization or surgery, placement in a child care program, addition of new equipment or technology, medication changes)		
4. Introduction of new or a change in: Service Provider (s) Service location (s)		
5. Termination of existing IFSP service		
6. Explore community program options for our: Child Family		
7. Child and Family exiting First Steps system due to Loss of eligibility Family does not consent to participate		
8. Other Transition		
Comments:		
Transition from (age 2.5 years): 9 & 10 required at each IFSP Meeting		
9. **Discussion** with, and training of parents regarding future placements and other matters related to the child's transition		
10. **Discussion** about procedures to prepare the child for changes in service delivery including steps to help the child adjust and function in a new setting		
11. **Send** with parental consent, information about the child to the local education agency to ensure continuity of services including evaluation and assessment of information and IFSP's		
12. **Send** specified information to community programs, upon informed, written consent, to facilitate service delivery or transition from the First Steps early intervention system		
Comments		

Child's Name:_____ Date:_____

Section 11: IFSP DEVELOPMENT TEAM AND CONTRIBUTORS

Printed Name	Position/Role	Agency (if applicable)	Telephone	Signature or Method of Participation

How will this team keep in touch? How often?

Child's Name _____ Current IFSP Date: _____ Revision Date _____

Section 12: IFSP Review Documentation Worksheet

☐ 6 Month Review ☐ Interperiodic Review

Team Evaluation Scales: 1= Situation changed: outcome not needed, 2= Situation unchanged; still need outcome, 3= Outcome partially attained, 4 = Outcome accomplished

Outcome #	Progress Summary	Team Evaluation	Modifications/Revisions

Missouri First Steps Early Intervention (EI) System
Individualized Family Service Plan (IFSP)

Instructions for Completion

The Individualized Family Service Plan (IFSP) describes how the First Steps Early Intervention System will assist each family in helping their very young child with a disability or developmental delay to grow and develop.

The information that follows is intended to assist Service Coordinators, Service Providers, families and all others involved in the consideration of the content and completion of the IFSP form to ensure that all agreed upon outcomes and services are documented for each eligible child and their family.

The IFSP form is divided into several sections. Each section has specific instructions for its completion. There are some general considerations that the IFSP team needs to be aware of when completing the form.

- It is the responsibility of the Intake/Service Coordinator to see that the IFSP document is completed. If the IFSP team wants to identify a recorder for the meeting to fill out the document, that is permissible, however, the Intake/Service Coordinator should always review the work of the recorder to confirm the accuracy of the contents of the IFSP.
- IFSP items marked with an asterisk (*) indicate information stored in the Central Finance Office (CFO) data system. However, this information is not always entered directly from the IFSP document. Some information is entered from other EI documents, such as the Referral form, Combined Enrollment form, etc. Care should be taken to ensure that the information in these fields on the IFSP is consistent with the corresponding information on other EI documents.
- The child's name and current IFSP date (m/d/y) must be on every page of the IFSP form. This helps to ensure that the child's IFSP document will be kept together and properly organized.
- Be sure that all information recorded on the IFSP is accurate and legible.
- Procedures for revising the IFSP are covered at the end of these instructions.

In addition to completing the IFSP document, intake/service coordinators' case notes must document, as appropriate, additional recommendations not reflected in the final IFSP document. These notes will indicate the extent to which particular services were recommended but not chosen by the family; e.g. certain levels of services were proposed but families opted for a different amount or the family chooses a provider who is not enrolled through the CFO.

Section 1: Child Information and Meeting Date Information

Purpose: This Section contains child identifying information. This Section also includes dates related to IFSP development, review, revisions and transition planning.

Child Information Instructions:

Child's name: Record the child's given or legal name.

Nickname: Record a nickname, if the child has one that is regularly used (i.e., "Chuck" for Charles.)

Gender: Identify the child as male, female or ambiguous.

Home Street/Address: Record the street address where the child is residing. This may be different from the address of the parent.

Mailing Address: This space is provided to identify when the address used for mailing purposes is different than the residence address (i.e., a P. O. Box).

Date Of Birth: Record the month, day and year of the child's birth.

Chronological Age: Record the age of the child in months.

Adjusted Age: If the child was premature, record the adjusted age in months. Adjusted age is calculated by deducting one-half of the prematurity from the child's chronological age. This adjusted age should generally only be assigned for up to 12 months, or longer, if recommended by the child's physician.

Reason for Eligibility: State the child's eligibility for First Steps as one of the following:

- newborn condition
- existing medical condition
- developmental delay(s)

This information can be obtained from the Eligibility Determination Form.

Native Language: Record the child's native language or mode of communication. Typical options include all varieties of spoken languages, American Sign Language (ASL), or methods of augmentative communication. *Native language* is the language normally used by the individual, or, in the case of a child, the language normally used by the parents of the child.

School District: Record the district in which the child resides.

SSN#: Record the Social Security Number for the child.

Directions to the child's home: Provide brief, accurate directions to the child's home. This information may be used by service providers.

IFSP Meeting Type and Meeting Date Instructions:

IFSP Meeting Type: Indicate by checking the box what type of IFSP meeting is being held.

Interim IFSP: When necessary, an IFSP may be completed prior to the completion of eligibility determination. This is intended to facilitate the provision of services in the event that a child has an immediate need for early intervention services. The interim IFSP must be developed by the team and contains the following: the name of the Service Coordinator, and the early intervention service required including type, intensity and duration. Implementation of an interim IFSP does not lengthen the 45-calendar day timeline in which the Service Coordinator must have eligibility determined and the IFSP completed.

Initial IFSP: For each child who has been determined eligible for the First Steps system, a meeting to develop the initial IFSP must be conducted within 45 calendar days of the referral. The Intake Coordinator at the SPOE is responsible for facilitating the development of the initial IFSP.

6 Month Review: Every IFSP must be reviewed at least every 6 months. The purpose of the 6-month review is to determine the degree to which progress toward achieving the outcomes is being

made, and whether revisions or modifications of the outcomes or services are necessary. If revisions are needed at this time, a new IFSP document must be developed.

Interperiodic Review: IFSP's will often require review and revisions because it is an evolving document that changes as the child and family needs change. An Interperiodic Review is any IFSP meeting that is held outside of the 6-month review and annual IFSP evaluation meetings.

Annual IFSP: The annual evaluation of the IFSP includes the requirement to use existing assessment and other information to develop outcomes that assist in identifying what early intervention services are needed and will be provided.

Transition: At least 6 months prior to the child's third birth date, the Service Coordinator must convene an IFSP meeting to discuss the transition process with the parents and other team members. At this meeting, the team reviews the child's program options for after age three and establishs a transition plan. **NOTE:** Transition planning **must** occur at every IFSP meeting, but the only time to identify the IFSP as a Transition IFSP is 6 months prior to the child's third birth date.

IFSP Meeting Date: Record the date (m/d/y) that the IFSP team met and the IFSP document was completed. If it takes more than one meeting to complete the IFSP, record the date of the meeting at which the IFSP was completed.

IFSP Start and End Date Instructions:

IFSP Start Date: Record the date (m/d/y) that services will begin. It is expected that services will begin as soon as possible following the IFSP meeting. If one or more services will not start on this date, that should be indicated in Column C in Section 7 of the IFSP.

IFSP End Date: Indicate the end date (m/d/y) for this IFSP. The end date may not be greater than 365 days from the IFSP meeting date or beyond the date of the child's third birthday, whichever comes first.

Exceptions to this occur when the IFSP covers services for a child under Missouri's "third birthday exceptions." The IFSP in this situation must be developed within the timelines and procedures of the third birthday policies. (See Missouri State Plan for Part C, Transition to Preschool Programs)

NOTE: Be aware that IFSPs do not expire. If the IFSP review is not conducted within one year, services documented on the IFSP must continue to be provided. If services are not continued, the agency may be considered to be out of compliance and compensatory services for the time that the services were not being provided considered. However, for a number of reasons, it is extremely important that the IFSP be reviewed within 365 days. First, as noted above, if the review is not conducted within 365 days of the date of the IFSP meeting, the agency may be considered to be out of compliance as an annual IFSP review is a state and federal requirement. Second, the annual review needs to be completed in a timely manner so that a determination can be made as to whether the services that are currently being provided are still appropriate to meet the needs of the child and the child's family. Finally, the review needs to occur in a timely manner in order for new authorizations to be completed for service providers.

In regard to payment authorizations for services providers, there is a failsafe provision in the CFO payment process which will extend authorizations for up to 30 days beyond the annual review date of the IFSP in order to allow time to get the IFSP review completed and new service authorizations completed. However, the best plan is to review the IFSP within the required timelines and not have to use this failsafe provision.

Section 2: Family Information

Purpose: This Section contains identifying information about the child's family &/or primary caregivers.

Primary Contact Information Instructions:

Primary Contact: List the name of the individual who will be the primary contact for this child. The primary contact should be the individual that has either physical custody or educational decisionmaking authority for the child.

Parent/Guardian/Foster Parent: Indicate the relationship of the primary contact to the child. Use one of the following choices:

Father	Grandmother	Legal Guardian
Mother	Grandfather	Educational Surrogate
Stepfather	Aunt	DFS Case Worker
Stepmother	Uncle	
Foster Father	Foster Mother	

In the case where parents live separately, even though both parents may share legal custody, the name of the parent who has physical custody of the child is recorded first and in the second Section, list the other parent. If both parents have legal custody, they both must receive written notice and both are decision makers in the IFSP process.

If the child is a ward of the state and has an Educational Surrogate. information appears under the "primary contact", and the DFS caseworker information should be placed under "other contact information."

Mailing Address: This space is provided to identify when the address used for mailing purposes is different than the residence address (i.e, a P. O. Box).

Home/Street Address: Record the street address of the primary contact.

Telephone: List the day and evening telephone numbers for the primary contact. Make sure to indicate if this is a home (h) or work (w) number. Confirm with the contact the best time to call and which phone number should be used.

E-mail(s): List e-mail address(es), if available.

Native language: Federal regulations require that families be provided information in their native language. Identification of this information will help to ensure that each family's active participation in the IFSP process and procedural safeguards are supported. Ask the family what their **native language** is and record this precisely. Native language means the language or mode of communication normally used by the parent of a child eligible for Part C services. If an interpreter is needed, be sure to indicate this as well.

Other Contact Information

Use this section to list information about other key contact individuals for the child. Additional pages may be used if more space is required to record information for these individuals.

Section 3: Service Coordinator Information

This section is used to record information about the child and family's On-going Service Coordinator. There is also space here to list information about the MC+ Contact Person and the child's Primary Care Physician.

Record the name and contact information of the individual who has been identified as the family's On-going Service Coordinator. This individual is selected by the family to assist them in the implementation, monitoring and evaluation of the IFSP. The Service Coordinator contact information should be reviewed regularly and verified for accuracy at least quarterly. This information may be completed prior to the IFSP meeting, and verified with family members and others early on in the meeting.

If the child has an MC+ Case Manager, this information should be recorded on this page.

List the name and contact information for the child's primary care physician, if known.

Section 4: Child's Present Level of Development--Abilities and Strengths

Purpose: Section 4 lists information about a child's present level of development, including their strengths and abilities in all of the following areas: physical development (including vision, hearing, and health status), cognitive development, communication development, social or emotional development, and adaptive development. Included in this section is any information about health, medical diagnosis and any precautions that must be addressed in activities with the child. <u>All areas of development must be addressed in this Section</u>.

Evaluation and assessments of infants and young children are intended to guide the planning of possible intervention approaches. Evaluation and assessment involve the review of multiple sources of information and assist both parents and professionals in understanding the child's competencies and resources. Assessment should represent an effort to understand infants and young children in the context of their family and of their care giving and learning environments. Scores obtained as a result of test activities are recorded on the Eligibility Determination Documentation and need not be repeated in the IFSP. Rather, the intent of this Section is to provide a narrative statement about the skills and abilities that the child currently demonstrates.

This information is used as a starting point for team discussion and the development of outcomes for the child and family. At each review of the IFSP, this page will be rewritten to reflect up-dated information. All evaluation or assessment reports will be kept in the child's early intervention (EI) record. Evaluation and assessment information should be reviewed with the family before the information is recorded on the IFSP.

<u>Instructions:</u>

Existing information including parent interview, structured observation, medical input, etc., should be used before any additional formal assessments are planned or conducted. In order to avoid unnecessary duplication of activities, it is important that the Intake/Service Coordinator and family members obtain and review relevant information, particularly information recorded on the eligibility determination form.

This form is considered a source document when completing this section of the IFSP and it is not necessary to repeat the information already recorded in the eligibility documentation.

Team Summary: Child's Present Abilities and Strengths: Basic identification information related to the eligible child is included on this page, including the documentation of what the child can do and what the child needs to learn. It is suggested that this Section be developed by the family prior to the IFSP meeting, and reviewed and expanded by the full IFSP Team at the IFSP development meeting. The IFSP Team develops the final language used to complete this Section in the IFSP.

In crafting the language in the Section, it is important to be positive, talking about the skills that the child has and how these are applied in daily living situations. This statement must include all developmental domains, and should indicate emerging skills and interests, skill quality and intent. Comments related to quality and intentions of movement are helpful once the basic skills are defined and discussed. Age equivalents, percent of delay, or standard deviations should not be included in this Section of the IFSP. The developmental domains are: cognition (thinking skills), language and communication, physical (fine and gross motor skills, vision, hearing & health status), adaptive skills such as eating, dressing and bathing, and social/emotional skills including how the child gets along with others.

Information on vision, hearing and health/physical/nutrition status must also be indicated. If there are no concerns in any of these areas denote it by putting "no concern" or "none", **do not leave the section blank**.

Other Strengths/Concerns [optional]: Other information relevant to the development of the IFSP, including birth history, diagnosis, or necessary precautions may be summarized here. Concise descriptions in behavioral, functional or diagnostic terms easily understandable to parents and caregivers should be used. This information should be included if it pertains to service planning or delivery; this Section is not meant to summarize the birth history unnecessarily. Pending surgery, new medications or equipment, health issues, etc., as well as birth and other historical health issues are all appropriate items to include in this Section if they influence the planning and delivery of services.

If there are no other influencing factors for the individual child, record N/A (not applicable) in this Section.

Application of this Section: Prior to the IFSP meeting, the family should be assisted to complete this Section in order to develop, in their own words, a statement of their child's skills in all developmental levels. The family statement would be used during the IFSP Team Meeting to provide the basis for the final summary, which is included in Section 4 of the IFSP.

Section 5: Summary of Family Concerns, Priorities And Resources (CPR) To Enhance The Development Of Their child

Purpose: State and federal regulations provide that, with the family's consent, an assessment of family concerns, priorities and resources (CPR) be conducted prior to the development of the IFSP. For those families that chose to participate in the assessment, this IFSP Section provides a standard method to document or summarize the information gathered during that assessment.

Instructions:

At the top of the page indicate whether or not the family gave their consent to participate in the family assessment. If the family consented to participate, insert the completed form into the IFSP. If the family did not consent, indicate that at the top of the form and leave the form blank.

Section 6: Child and Family Centered Outcomes

Purpose: This Section provides the format for defining individual outcomes related to the child and family's needs. It includes identification of the current status, specific objectives and strategies for addressing and achieving the outcome. State and federal regulations require the IFSP Team to conduct an IFSP review at least every six months to assess the child's progress towards achievement of outcomes and whether modifications or revisions of the outcomes or services is necessary. Evaluation of the entire IFSP is required at least annually.

If the family completes Section 5 of the IFSP (Summary of Family Concerns, Priorities and Resources), the IFSP team needs to consider this information when developing outcome(s).

There will be only one (1) outcome per page. Each outcome will be numbered consecutively.

It is important during the IFSP Team meeting to discuss the provision of service coordination with the entire team and develop specific understanding and strategies that will detail the mutually-agreed upon activities of the Service Coordinator. The routine obligations of the Service Coordinator (monitoring, review and evaluation of the IFSP) as well as other activities that are agreed to be provided by this person, should be reflected either as an outcome in the IFSP, or as a strategy within an outcome.

Instructions:

Outcome: Record a statement here of what the team would like to see happen, and why, for the child &/or the family. The focus of this outcome statement is to clearly describe what difference or change for the family will occur once this outcome is achieved. Language describing the change desired and what this means for the child and/or family is part of the outcome statement.

Strategies and Activities: What are the strategies, activities or next steps that need to occur to achieve the outcome?

This section is optional and can provide a strong basis for making sure the team discusses information gathered from the family about the daily routines of the child and family and the environments in which it makes sense to embed the services. Consider the outcomes that are developed within the context of natural environments and routines identified by this family and document ideas for addressing the outcomes within those routines. What are some strategies for using materials and resources that are already available within those environments and helping find ways to address the identified needs using those naturally occurring resources and supports?

The worksheet "Identifying Typical Family Routines and Activities" that is completed with the family during IFSP planning should be a helpful tool for initiating these discussions about strategies during the IFSP meeting.

Time Line: Indicate when the outcome will be measured for progress by the IFSP team.

Procedure: Indicate how the team plans on measuring progress toward the outcome. The team should state how they will monitor and measure change including observations, report, etc.

Criteria: Indicate what needs to be accomplished for the outcome to be fully met. This should tie back to the outcome in that there will be an observable change to the family and the other team members. This change may be developmental or it may be related to improvements in a daily activity.

Application of this Section: Families should be assisted by their Service Coordinator to develop outcome statements that are important to them before attending the IFSP Team Meeting. By listening carefully to families, the Service Coordinator can help the family to put into words those things that are most meaningful to them. In order for the family to have active and informed participation in the IFSP development meeting, they need to have time and opportunity before the meeting to discuss what they need.

The family should be assisted to come to the IFSP Team meeting with their thoughts on paper, so that they have materials to refer to from time to time during the meeting. This type of preparation is no different than the preparation conducted by various professionals in anticipation of an IFSP meeting. Having a prepared and actively participating family ensures that the family's needs are the primary focus of all IFSP Team members.

Section 7: Early Intervention Services

Purpose: Section 7 of the IFSP is a summary of the services necessary to meet the unique needs of the child and family. Specific information, including the **type** of service, **how often** the service is to be provided, when the service is to begin and for **how long,** must be included in the IFSP document. Also required is information regarding **where** services are delivered, **who** will provide the service and **what funding source** will be used to pay for early intervention services.

State and federal regulations require that, to the maximum extent appropriate, Early Intervention services must be provided in natural environments (e.g., the home, child care centers, or other community settings). Natural environments are defined as those settings that are natural or normal for the child's age peers who have no disabilities. For most infants and toddlers, services will be provided in the Natural Environment. For some infants and toddlers, the appropriate location of services might be another setting—for example, a hospital during the period in which they require extensive medical interventions or a clinic which houses specialized therapy equipment.

When determining the location for the provision of services, it will be helpful if the Service Coordinator has completed the worksheet "Identifying Typical Family Routines and Activities" with the family. By having information of the location(s) in which the child spends his/her day, this will assist the team when they are considering location for the provision of services in natural environments for the child.

Section 7 should be completed only **after** the outcomes and strategies/ activities are identified. The IFSP Team will identify those services necessary to meet the identified outcomes, and will strive to establish the delivery of these services in a natural environment for the child and family. It is the responsibility of the IFSP Team to ensure that each family is fully informed of the services that are **available** under Part C and that those services **identified to be provided** are **allowable** services under Part C and that services are based upon documented need.

Any identified services must have informed, written parental consent prior to their being provided. **Parents may decline any specific service recommended by the IFSP Team without jeopardy to the child's eligibility, or to the other services on the IFSP.** Notations of this discussion should be made in the Intake/Service Coordinator's case notes and maintained in the child's early intervention record.

COMMENT: Specific services may be needed only temporarily or additional outcomes may be identified because of progress made or changes in the family. This document is a tool, a blueprint for services. Often, that blueprint must be modified to meet new challenges or decisions made by the family. The Individualized Family Service Plan can change as often as necessary through the IFSP meeting process. Each additional outcome may identify a need for additional strategies or activities. These can be added when determined necessary by the IFSP team.

Instructions:

Column A: **Outcome(s):** Record the outcome number(s) following #. There may be more than one service per outcome and more than one outcome per service.

Column B: **EI Service(s):** List the identified service(s) that have been agreed upon to address this outcome**.** Early Intervention services may include:

Occupational Therapy	Physical Therapy
Audiological Services	Psychological Services
Special Instruction	Service Coordination*
Health Services	Social Work Services
Medical Diagnostic Services	Speech/Language Therapy
Nursing Services	Transportation**
Nutrition Services	Vision Services

Assistive Technology Devices and Services* *

*Service coordination **must be listed** on **every** IFSP. If the family declines Service Coordination, it is considered to be a refusal of all First Steps services.

** These services must be documented on the applicable authorization forms for these services and then attached to the IFSP. See Section 7a and 7b for additional instructions.

Column C: **Start Date:** Record (m/d/y) when the service will begin. The date must be within the effective dates of the IFSP and should be as soon as possible after the IFSP meeting date.

Column D: **End Date:** Record the end date (m/d/y) for the service, not to exceed 365 days or go beyond the day before the child's third birthday.

Exceptions to this occur when the IFSP covers services for a child under Missouri's "third birthday exceptions." The IFSP under this situation must be developed within the timelines and procedures of the third birthday policies. (See Missouri State Plan for Part C, Transition to Preschool Programs)

Column E: **Provider:** List the name(s) of the person(s) and the agency/independent, as applicable, who will provide the service. Phone number(s) and/or address(es), including e-mail addresses will assist with ongoing communication.

Column F: **Method:** There may be more than one method per service, however only one code can be listed per line on the form. Codes for method of service delivery are:

1 – Consultation/Facilitation with others
Definition/Examples: First Steps providers guide adult caregiver(s) with specific intervention strategies. May also make suggestions for modifications to the environment, develop accommodations, etc. May include consultation with child care provider, visiting a family with another provider, assisting others to prepare for the child's transition to other or new services, etc.

2 – Family Education, Training and Support
Definition/Examples: Specifically planned training designed for family members such as specialized sign language training, a course of study designed especially for parents regarding a specific training technique including behavior management, intervention strategy, disability, etc. The child is typically not present for this service type.

3 – Direct Child Service
Definition/Examples: This includes a direct service provided to the child, typically with a primary caregiver present and observing the interaction. May also include parent training in positioning, language stimulation, etc.

Column G: Indicate whether the service is provided in an individual or group setting. Group settings are only applicable to Special Instruction and Speech therapy services.

Column H: **Location:** Record the specific location from the legend below:
A: Home (child's home, including foster home)
B: Other Family Location (grandparent, aunt, etc.)
C: Community Setting (child/daycare, preschool other than "B" above)
D: Special Purpose Center or Clinic (includes hospital, residential facility, service provider location, & "other")
There can be more than one location per service, however, each location needs to be recorded on a separate line on the form.

Column I: **Frequency:** Record the agreed upon number of days or sessions and indicate whether this frequency is by the week (WK) or month (MO).

Column J: **Intensity:** Record the length of time that the service is to be provided (e.g. "30 minute session"). Do not use descriptors such as "as needed" or "to be determined."

Column K: **Funding Source:** Insert the code letter for the funding source which is to be used or billed for the service.
A: Central Finance Office (CFO) (First Steps, Title V (Medicaid))
B: DMH/MRDD for service coordination provided by this agency

Column L: **Initial/Revision/Addition:** Indicate if this is an initial service, a service that is being revised, or a service that is being added.

Primary Setting for this IFSP:
The IFSP Team must identify a primary setting where IFSP services will be provided. Once all of the services have been identified, the Team reviews the various strategies and settings and determines which one of the following settings most accurately defines where the majority of services will be provided. This consideration includes looking at the frequency and intensity of all services in addition to the specific location codes. Circle the one determined to be the primary setting. Setting options are:

1. Special purpose facility: program designed specifically for children with developmental delays or disabilities.
2. Community setting: program designed primarily for typically developing children. Includes childcare settings, preschools, and other community programs.
3. Home: In addition to the child's own home, this may include the provision of service in a relative's home.
4. Hospital: Refers to inpatient services only.
5. Residential facility
6. Service provider location: This location would include a clinic or provider's office where the family receives service.
7. Other setting: Use the actual location descriptor.

Section 7a. Assistive Technology (AT) Authorization

IFSP Meeting Date: Enter the date of the IFSP meeting in which the need for specific AT was discussed.

IFSP Outcome Number: List the IFSP outcome number(s) for which the AT service has been determined necessary by the IFSP team.

Start Date: List the start date for this service.

End Date: List the end date for this service.

Provider: Enter the name of the provider of this service.

HCPCS Code: Fill in the appropriate HCPCS code for the item to be purchased.
Description of Item: Fill in the description of the item that corresponds to the HCPCS code.

Type: Indicate whether the item is to be purchased, rented, or repaired.

Quantity: Indicate the number of item(s) to be purchased.

Price: Enter the cost of the item in dollars and cents. If purchasing more than one item, fill in the unit cost per item.

Section 7b. Transportation Authorization

Start Date: Fill in the start date for transportation.

End Date: Fill in the end date for transportation.

Provider: Indicate the name of the provider who will be providing the service.

Frequency: Indicate the number of trips per authorization, week, month, or year.

Maximum Miles Per Trip: Indicate the maximum number of miles per trip.

Section 8: Natural Environments Justification

Purpose:

The Natural Environments (NE) Justification form must be completed once the IFSP services have been identified, **if all or any of the services will not be provided in a Natural Environment.** A justification must be completed for **each** service that is being provided **outside** of the natural environment. If all services are being provided in Natural Environments, this section will not need to be completed. This page may also be reproduced if needed.

Instructions:

Outcome#: Write the outcome number from Section 7 for which you have identified a service that will be provided outside of the natural environment.

Service: Indicate which service was identified in the outcome as being provided outside of the natural environment.

Environment: State the specific location identified for the provision of the service (see Section 7, Column H).

Justification: Explain why the IFSP Team determined that it was not appropriate to provide this service in a natural environment. This explanation should describe what the IFSP Team discussed to make the determination that it was necessary to provide early intervention services in a setting other than a natural environment and how it was determined that the selected environment would more effectively facilitate achievement of this outcome.

Section 9: Other Services

Purpose: This Section provides the opportunity for the IFSP Team to review any other services identified as necessary to meet child and family outcomes. These other services, while not required or eligible under Part C, are responsive to overall child and family needs (e.g. in-home support, respite care, medical equipment, etc.) The IFSP must include specific information about these services, ensuring that consideration has been given to all potential sources and strategies to support the family's identified outcomes, however, **there is no obligation of the Part C system to fund these services.**

Section 9 encourages the identification of other family support services as well as preventive medical and health services for the eligible child and family. These services may include those identified through the family assessment of concerns, priorities and resources (Section 5) or reflect services that support the family in areas beyond the early intervention system. The Service Coordinator works with the family members to monitor the delivery and evaluation of these services on a routine basis.

Instructions:

Service(s): Record here the name of the service.

Family/Child Service: Depending upon who the service is provided to, circle family or child.

Responsible Individual: Write in the name of the person or agency who will provide this service.

Funding Source: Indicate the funding source to pay for this service. Possible funding sources for these services are: Medicaid, private insurance, other federal, state and local disability funds, etc. **Part C cannot be indicated here as a possible funding source**.

Section 10: Transition WorkSheet

Purpose:

Transition planning is a component of each IFSP development, review or evaluation activity, and it is conducted to ensure that services continue to be provided without unnecessary interruption. Transition planning also helps to ensure that the child and/or family will experience success and benefit from the planned services by preparing them appropriately for any changes.

State and federal regulations require that IFSP teams plan for a child's transition out of the Part C (First Steps) system at age three. Each IFSP, must include documentation of the steps to be taken to support that transition, whether that transition will be to preschool services under Part B (Early Childhood Special Education) or to other services that may be available, such as Parents as Teachers, Head Start, Title I Preschool programs, etc. Then, at least six months prior to the child's third birthday a Transition IFSP meeting must be held to discuss this transition and to document the steps needed to accomplish a smooth and effective transition.

Transition planning for the infant or very young toddler will often involve introducing the parents to information about the transition process and the choices that will occur when the child approaches age three. For the older toddler, the transition planning becomes more specific.

It should be noted that while IDEA requires specific procedures for transition in relation to the changes that occur for the child and the family at the child's third birthday, it is also good practice to consider other transitions that occur not only as the child moves from the system, but also into and within the system (hospitalizations, changes of service provider, family moves, movement from the hospital to home, the anticipation of surgery for the young child, the addition of new medications or technology, family issues such as employment, the birth of a new child, etc.). Planning for these other transitions should be documented in the IFSP along with the required documentation of the transition planning related to exiting First Steps at age three.

Instructions:

Specific Transition Issue: The transition points in the left hand column serve as reminders or "prompts" to the family and IFSP Team as to the variety of transitions that may occur for a child and family. Transitions have been divided into two sections ("Into and Within" and "Transition From") First Steps. Note that Items 1-8 in the section "Transition into and within" are optional. It is good practice that these areas be considered, but they are not requirements. Items 9 and 10 in the "Transition from (age 2.5 years)" are **required items** to be completed at each IFSP review. Items 11 and 12 would be completed, as appropriate, to facilitate the child's transition to ECSE or other programs at age three, with the parent's consent.

Who is Responsible: The IFSP Team member assigned to follow-through on the specific issue should be identified here.

Effective practice is for transition needs to be incorporated into the IFSP as relevant to the provision of IFSP service(s) or if the transition is defined by the parent as significant. Under these circumstances, transition planning needs may be extended into at least one (1) outcome statement in the IFSP, with detail provided as to the strategies and activities planned to achieve successful transition OR these needs may be incorporated as a strategy or activity within an existing Outcome.

While other transitions may occur, they may not be of the nature or consequence that the family or remainder of the IFSP Team feels will influence the successful implementation of the IFSP.

For example, the termination of a service for one family may not require any transition planning; for another family, it may be important to plan for the gradual reduction of services depending upon the individual child and family needs. For some children, the change of provider may be significant and require considerable transition planning. Teams should use good judgment in delineating the significance of transitions on an individualized basis and incorporate these issues into the IFSP appropriately.

Application of this Section: This Section should be developed in advance of the IFSP Team meeting with the family and serves as a discussion and planning point for the entire Team.

Section 11: IFSP Development Team and Contributors

Purpose: This Section lists information about the people who participated in or contributed to the IFSP development, including those who conducted evaluation or assessments but did not attend the IFSP meeting.

Each initial meeting and each annual meeting must include the following:

1. The parent(s) of the child
2. Other family members, as requested by the parent, if feasible to do so
3. An advocate or person outside of the family, if the parent requests that the person participate
4. The Intake &/or On-going Service Coordinator
5. A person or persons directly involved in conducting the evaluations and assessments of the child
6. As appropriate, persons who will be providing services to the child or family

If the person or persons involved in conducting the evaluations and assessments of the child (#5 above) is unable to attend the IFSP meeting, arrangements must be made for the person's involvement through other means including telephone conference call, having a knowledgeable authorized representative attend the meeting, or making pertinent records available at the meeting.

For each periodic review of the IFSP, the individuals indicated in #1-4 above must be in attendance and, if conditions warrant, provisions must be made for the attendance of those individuals listed in #5 & #6.

Instructions:

Name: Record all individuals who have participated in the development of the IFSP. Include name, role, agency, and phone number.

Method of Participation:
Define the method of participation of the team members. The member's signature reflects their attendance at the IFSP Team meeting. In the case of an initial IFSP or annual IFSP review, if an individual involved in conducting an evaluation/assessment of the child was not present, the Intake/Service Coordinator must designate the method of participation for that individual, such as "submitted written report," "provided verbal recommendations," "conference call," "sent representative," etc. If that person sent an authorized representative, the representative should list their name and indicate after their signature who they are representing.

How will this team keep in touch? How often?
Before formally ending the IFSP Team meeting, team members should discuss the frequency and method for keeping in touch with one another, including plans for routine correspondence, telephone calls, and progress reports. This is also an excellent time to schedule the six-month review date with the Team.

Section 12: IFSP Review and Early Intervention Service Revisions

Purpose: This provides a format to document changes/updates to the IFSP. The IFSP will require modification because it is an evolving document that changes as the child and family needs change. This form will only be used for six-month or interperiodic reviews.

The review of an outcome may be prompted by an expressed need by a team member, including the family, to change an existing service. Concurrently, in reviewing an outcome, the IFSP Team may decide that revisions in service delivery must be made in order to successfully make progress on the outcome. Once this outcome review is conducted indicating the direction for change in service, the Review Section must be completed indicating the service to be modified and the particulars (such as termination, addition, or change in frequency, location, duration, intensity).

IFSP Review
Instructions:

Review Cycle: Fill in the box in front of the type of review that is occurring, either six-month or interperiodic.

Outcome #: List outcome number from IFSP.

Progress Summary: Record parents and providers' overall conclusions based on the review and references to outcomes from the current IFSP.

Team Evaluation: Insert the appropriate numbers from the Team Evaluation Scale to indicate the team's corresponding assessment of the situation.

Modifications/Revisions: Record parents' and providers' changes in ideas and activities, or circumstances, which will impact outcomes.

In addition to completing this form, any changes to an IFSP must be applied to each Section of the IFSP that requires revision. Once all revisions are made to the pertinent sections, the remainder of the IFSP document left unchanged may be photocopied. If Section 7 requires revisions make needed changes to that section and mark the changes in column L as a revision or addition. For revisions, the documents that will be required are as follows: a new cover page (indicating date and type of meeting), Section 12, and the photocopied IFSP with any new sections. Each IFSP must be reviewed at least six months after initial development. The development of an inter-periodic IFSP will not result in a new date for annual IFSP. This entire IFSP document needs to be provided to all IFSP Team members including the family; the original is filed with the SPOE in the EI Record.

If the only changes required are provider name and/or funding sources, make the change directly on the current Section 7 of the IFSP by crossing out the old information and adding the correct information and current date. The Service Coordinator sends a copy of this page to the SPOE. **All other changes – e.g. frequency, intensity, location etc. require an IFSP team meeting and documentation as shown above under Modifications/Revisions**. **This is the only exception to the rule that IFSP revisions require an IFSP team meeting.**

The IFSP is assembled as earlier discussed, with the cover page first followed by the modifications pages. The Sections of the IFSP that have been changed are integrated with copies of the other Sections that remain unchanged. All of these pages constitute the revised IFSP which is then copied and distributed to all IFSP Team members; the original document is maintained at the SPOE in the EI Record.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

The Individualized Family Service Plan describes
how the First Steps early intervention system will assist each family in helping
their very young child with a disability or developmental delay to grow and develop.

Missouri First steps EARLY INTERVENTION

Section 1: CHILD INFORMATION

*Child's Name:_____*Nickname: _____*Gender: M F A

*Home Street/Address: _____*Mailing Address: _____

*City/Town: _____MO, Zip: _____ *County: _____

*Date of Birth: _____ Chronological Age: _____Adjusted Age: _____

*Reason for Eligibility: _____*Native Language : _____

*School District:_____*SSN#: _____ *Medicaid #: _____

DIRECTIONS TO CHILD'S HOME

***MEETING DATE INFORMATION:**

IFSP Meeting Type:

☐ Interim ☐ Initial ☐ 6 Month Review ☐ Interperiodic Review ☐ Annual ☐ Transition

Meeting Date: ____/ ____/ ____

IFSP Start Date: _____/_____/_____ IFSP End Date: _____/_____/____

Child's Name: _____ Date: _____

Section 2: FAMILY INFORMATION

*Primary Contact: _____

*Relationship to child: _____

*Mailing Address: _____

*City/Town: _____*State: _____*Zip: _____

*Home/Street Address: _____

*Day Phone: _____ (h___ w___)
*Evening Phone: _____ (h___ w___)
*Best time to call: _____
E-mail: _____
Other way to contact: _____
*Native language:_____
*Interpreter Needed? Yes No

OTHER CONTACT INFORMATION:
*Name: _____

*Relationship to child: _____

*Mailing Address: _____

*City/Town: _____*State: _____*Zip: _____
*Home/Street Address:_____
*Day Phone: _____ (h___ w___)
*Evening Phone: _____ (h___ w___)
*Best time to call: _____
E-mail: _____

Section 3. SERVICE COORDINATOR CONTACT INFORMATION

*Name: _____

*Agency: _____

*Work Telephone: _____

*Cell Phone: _____

*Best time to call: _____

*FAX: _____

*E-mail address: _____

Mailing Address: _____

City/Town: _____

*State: _____ *Zip: _____

*MC+/Plan Contact Person : _____

*Telephone:_____ *FAX Number: _____

*Physician: _____

*Address: _____

*City/Town: _____, State: _____ Zip: _____

Telephone: _____ FAX:_____

E-mail: _____

Child's Name: _____ Date: _____

Section 4: CHILD'S PRESENT ABILITIES AND STRENGTHS: TEAM SUMMARY.

WHAT MY CHILD CAN DO NOW - INTERESTS, MOTIVATORS, NEW SKILLS, THINGS TO CELEBRATE, WHAT MY CHILD IS READY TO DO, WHAT'S WORKING WELL. Make sure that all developmental domains are included. Describe in an integrated, functional manner how this child: does things for him/herself (Adaptive/Self Help Skills); how s/he problem solves and plays (Cognition); how s/he uses hands, oral motor skills, how s/he moves around (Physical Skills); how s/he indicates understanding, wants, and needs (Communication Skills); and how s/he shows feelings, copes with frustration or stimulation, and gets along with others (Social/Emotional Skills).

Adaptive Self Help:

Cognition:

Physical:

Communication:

Social/Emotional:

Vision / Hearing:

Health/Physical/Nutrition Status:

Other Strengths/Concerns including relevant information (medical diagnosis, birth history, health status, sensory issues, etc.) or other concerns, which might affect service delivery.

Child's Name: _____ Date: _____

Section 5. SUMMARY OF FAMILY CONCERNS, PRIORITIES AND RESOURCES TO ENHANCE THE DEVELOPMENT OF THEIR CHILD

Family declined consent to complete an assessment of family concerns, priorities and resources: Yes No (If "yes" leave this section blank, If "no" this section must be completed.)

I have questions about or want help for my child in the following areas:

- ☐ Moving around (crawling, scooting, rolling, walking)
- ☐ Ability to maintain positions for play
- ☐ Talking and listening
- ☐ Thinking, learning, playing with toys
- ☐ Feeding, eating, nutrition
- ☐ Having fun with other children; getting along
- ☐ Behaviors and feelings
- ☐ Toileting; getting dressed; bedtime; other daily routines
- ☐ Helping my child calm down, quiet down
- ☐ Pain or discomfort
- ☐ Special health care needs
- ☐ Seeing or hearing
- ☐ Other: _____

I would like to share the following concerns and priorities for myself, other family members, or my child:

- ☐ Finding or working with doctors or other specialists
- ☐ How different services work or how they could work better for my family
- ☐ Planning for the future; what to expect
- ☐ Parenting skills
- ☐ People who can help me at home or care for my child so I/we can have a break; respite or child care
- ☐ Housing, clothing, jobs, food, or telephone
- ☐ Information on my child's special needs, and what it means
- ☐ Ideas for brothers, sisters, friends, extended family
- ☐ Money for extra costs of my child's special needs
- ☐ Linking with a parent network to meet other families or share information
- ☐ Other: _____

FAMILY'S CONCERNS ABOUT THEIR CHILD

PRIORITIES OF THE FAMILY (Select from items checked to the left)

STRENGTHS, RESOURCES THAT OUR FAMILY HAS TO MEET OUR CHILD'S NEEDS

Child's Name: _____ Date: _____

Section 6. FAMILY AND CHILD CENTERED OUTCOME(S) **This page should be duplicated as needed**

Outcome # _____:

Optional: Strategies and Activities: (Summarize ideas for addressing the outcome within the child and family's naturally occurring routines and environments using people and materials that are available there. This is not a listing of early intervention services)

When will we as a team measure progress towards this outcome? (timeline)

How will we, as a team, measure progress towards this Outcome? (procedure)

Our team will be satisfied we are finished with this Outcome when: (criteria)

Child's Name: _____ Date: _____

Section 7. *EARLY INTERVENTION RESOURCES, SUPPORTS AND SERVICES This entire page is part of electronic record.

Column A	Col. B	Column C	Column D	Col. E	Col. F	Col. G	Col. H	Col. I	Col. J	Col. K	Col. L
Outcome(s) #	Early Intervention Service(s)	Start Date	End Date	Provider(s) Name	Method (see below)	Ind. Or Group	Location (see below)	Frequency	Intensity	Funding Source	Initial (I) Addition (A) Revision (R)
#											
#											
#											
#											

1) Column F, Method Code: 1 = Consultation/Facilitation with Others; 2 = Family Education/Training/Support; 3 = Direct Child Service
2) Column H, Location Code: 1 = Home; 2 = Other Family Location; 3 = Community Setting; 4 = Special Purpose Center or Clinic

Primary Setting for this IFSP: (circle) special purpose facility - community setting - home - hospital - residential facility - service provider location - other setting

Child's Name_____ Date:_____

***Section 7a. Assistive Technology Authorization – IFSP Meeting Date:_____**

IFSP Outcome #	Start Date	End Date	Provider	HCPCS Code	Description of Item	• Purchase • Rental • Repair	Quantity	Price	Remarks (Optional)

***Section 7b. Transportation Authorization**

IFSP Outcome #	Start Date	End Date	Provider	Frequency	Maximum miles per trip

Child's Name: _____ Date: _____

Section 8: Natural Environments Justification

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Child's Name _____ Date: _____

Section 9: * Other Services **This entire section is part of the electronic record.**

Service	Family or Child Service	Responsible Individual	Fund Source
	family / child		
	family / child		
	family / child		
	family / child		
	family / child		

Child's Name: _____ Date: _____

Section 10: Transition Checklist

Transition Activities into, within and from First Steps: Identification of activities and responsible individuals to assist the family and child with transitions include:	Specific Transition Issue	Who is responsible
Transition into and within: (Optional)		
1. Transition from hospital, neonatal intensive care unit to home, and into early intervention services to ensure that no disruption occurs in necessary services		
2. Family related changes that may affect IFSP service delivery i.e., employment, birth or adoption of sibling, medical needs of other family members)		
3. Child related changes that may affect IFSP service delivery (i.e., hospitalization or surgery, placement in a child care program, addition of new equipment or technology, medication changes)		
4. Introduction of new or a change in: Service Provider (s) Service location (s)		
5. Termination of existing IFSP service		
6. Explore community program options for our: Child Family		
7. Child and Family exiting First Steps system due to Loss of eligibility Family does not consent to participate		
8. Other Transition		
Comments:		
Transition from (age 2.5 years): 9 & 10 required at each IFSP Meeting		
9. **Discussion** with, and training of parents regarding future placements and other matters related to the child's transition		
10. **Discussion** about procedures to prepare the child for changes in service delivery including steps to help the child adjust and function in a new setting		
11. **Send** with parental consent, information about the child to the local education agency to ensure continuity of services including evaluation and assessment of information and IFSP's		
12. **Send** specified information to community programs, upon informed, written consent, to facilitate service delivery or transition from the First Steps early intervention system		
Comments		

Child's Name:_____ Date:_____

Section 11: IFSP DEVELOPMENT TEAM AND CONTRIBUTORS

Printed Name	Position/Role	Agency (if applicable)	Telephone	Signature or Method of Participation

How will this team keep in touch? How often?

Child's Name _____ Current IFSP Date: _____ Revision Date _____

Section 12: IFSP Review Documentation Worksheet

☐ 6 Month Review ☐ Interperiodic Review

Team Evaluation Scales: 1= Situation changed: outcome not needed, 2= Situation unchanged; still need outcome, 3= Outcome partially attained, 4 = Outcome accomplished

Outcome #	Progress Summary	Team Evaluation	Modifications/Revisions

Missouri First Steps Early Intervention (EI) System
Individualized Family Service Plan (IFSP)

Instructions for Completion

The Individualized Family Service Plan (IFSP) describes how the First Steps Early Intervention System will assist each family in helping their very young child with a disability or developmental delay to grow and develop.

The information that follows is intended to assist Service Coordinators, Service Providers, families and all others involved in the consideration of the content and completion of the IFSP form to ensure that all agreed upon outcomes and services are documented for each eligible child and their family.

The IFSP form is divided into several sections. Each section has specific instructions for its completion. There are some general considerations that the IFSP team needs to be aware of when completing the form.

- It is the responsibility of the Intake/Service Coordinator to see that the IFSP document is completed. If the IFSP team wants to identify a recorder for the meeting to fill out the document, that is permissible, however, the Intake/Service Coordinator should always review the work of the recorder to confirm the accuracy of the contents of the IFSP.
- IFSP items marked with an asterisk (*) indicate information stored in the Central Finance Office (CFO) data system. However, this information is not always entered directly from the IFSP document. Some information is entered from other EI documents, such as the Referral form, Combined Enrollment form, etc. Care should be taken to ensure that the information in these fields on the IFSP is consistent with the corresponding information on other EI documents.
- The child's name and current IFSP date (m/d/y) must be on every page of the IFSP form. This helps to ensure that the child's IFSP document will be kept together and properly organized.
- Be sure that all information recorded on the IFSP is accurate and legible.
- Procedures for revising the IFSP are covered at the end of these instructions.

In addition to completing the IFSP document, intake/service coordinators' case notes must document, as appropriate, additional recommendations not reflected in the final IFSP document. These notes will indicate the extent to which particular services were recommended but not chosen by the family; e.g. certain levels of services were proposed but families opted for a different amount or the family chooses a provider who is not enrolled through the CFO.

Section 1: Child Information and Meeting Date Information

Purpose: This Section contains child identifying information. This Section also includes dates related to IFSP development, review, revisions and transition planning.

Child Information Instructions:

Child's name: Record the child's given or legal name.

Nickname: Record a nickname, if the child has one that is regularly used (i.e., "Chuck" for Charles.)

Gender: Identify the child as male, female or ambiguous.

Home Street/Address: Record the street address where the child is residing. This may be different from the address of the parent.

Mailing Address: This space is provided to identify when the address used for mailing purposes is different than the residence address (i.e., a P. O. Box).

Date Of Birth: Record the month, day and year of the child's birth.

Chronological Age: Record the age of the child in months.

Adjusted Age: If the child was premature, record the adjusted age in months. Adjusted age is calculated by deducting one-half of the prematurity from the child's chronological age. This adjusted age should generally only be assigned for up to 12 months, or longer, if recommended by the child's physician.

Reason for Eligibility: State the child's eligibility for First Steps as one of the following:

- newborn condition
- existing medical condition
- developmental delay(s)

This information can be obtained from the Eligibility Determination Form.

Native Language: Record the child's native language or mode of communication. Typical options include all varieties of spoken languages, American Sign Language (ASL), or methods of augmentative communication. *Native language* is the language normally used by the individual, or, in the case of a child, the language normally used by the parents of the child.

School District: Record the district in which the child resides.

SSN#: Record the Social Security Number for the child.

Directions to the child's home: Provide brief, accurate directions to the child's home. This information may be used by service providers.

IFSP Meeting Type and Meeting Date Instructions:

IFSP Meeting Type: Indicate by checking the box what type of IFSP meeting is being held.

Interim IFSP: When necessary, an IFSP may be completed prior to the completion of eligibility determination. This is intended to facilitate the provision of services in the event that a child has an immediate need for early intervention services. The interim IFSP must be developed by the team and contains the following: the name of the Service Coordinator, and the early intervention service required including type, intensity and duration. Implementation of an interim IFSP does not lengthen the 45-calendar day timeline in which the Service Coordinator must have eligibility determined and the IFSP completed.

Initial IFSP: For each child who has been determined eligible for the First Steps system, a meeting to develop the initial IFSP must be conducted within 45 calendar days of the referral. The Intake Coordinator at the SPOE is responsible for facilitating the development of the initial IFSP.

6 Month Review: Every IFSP must be reviewed at least every 6 months. The purpose of the 6-month review is to determine the degree to which progress toward achieving the outcomes is being

made, and whether revisions or modifications of the outcomes or services are necessary. If revisions are needed at this time, a new IFSP document must be developed.

Interperiodic Review: IFSP's will often require review and revisions because it is an evolving document that changes as the child and family needs change. An Interperiodic Review is any IFSP meeting that is held outside of the 6-month review and annual IFSP evaluation meetings.

Annual IFSP: The annual evaluation of the IFSP includes the requirement to use existing assessment and other information to develop outcomes that assist in identifying what early intervention services are needed and will be provided.

Transition: At least 6 months prior to the child's third birth date, the Service Coordinator must convene an IFSP meeting to discuss the transition process with the parents and other team members. At this meeting, the team reviews the child's program options for after age three and establishs a transition plan. **NOTE:** Transition planning **must** occur at every IFSP meeting, but the only time to identify the IFSP as a Transition IFSP is 6 months prior to the child's third birth date.

IFSP Meeting Date: Record the date (m/d/y) that the IFSP team met and the IFSP document was completed. If it takes more than one meeting to complete the IFSP, record the date of the meeting at which the IFSP was completed.

IFSP Start and End Date Instructions:

IFSP Start Date: Record the date (m/d/y) that services will begin. It is expected that services will begin as soon as possible following the IFSP meeting. If one or more services will not start on this date, that should be indicated in Column C in Section 7 of the IFSP.

IFSP End Date: Indicate the end date (m/d/y) for this IFSP. The end date may not be greater than 365 days from the IFSP meeting date or beyond the date of the child's third birthday, whichever comes first.

Exceptions to this occur when the IFSP covers services for a child under Missouri's "third birthday exceptions." The IFSP in this situation must be developed within the timelines and procedures of the third birthday policies. (See Missouri State Plan for Part C, Transition to Preschool Programs)

NOTE: Be aware that IFSPs do not expire. If the IFSP review is not conducted within one year, services documented on the IFSP must continue to be provided. If services are not continued, the agency may be considered to be out of compliance and compensatory services for the time that the services were not being provided considered. However, for a number of reasons, it is extremely important that the IFSP be reviewed within 365 days. First, as noted above, if the review is not conducted within 365 days of the date of the IFSP meeting, the agency may be considered to be out of compliance as an annual IFSP review is a state and federal requirement. Second, the annual review needs to be completed in a timely manner so that a determination can be made as to whether the services that are currently being provided are still appropriate to meet the needs of the child and the child's family. Finally, the review needs to occur in a timely manner in order for new authorizations to be completed for service providers.

In regard to payment authorizations for services providers, there is a failsafe provision in the CFO payment process which will extend authorizations for up to 30 days beyond the annual review date of the IFSP in order to allow time to get the IFSP review completed and new service authorizations completed. However, the best plan is to review the IFSP within the required timelines and not have to use this failsafe provision.

Section 2: Family Information

Purpose: This Section contains identifying information about the child's family &/or primary caregivers.

Primary Contact Information Instructions:

Primary Contact: List the name of the individual who will be the primary contact for this child. The primary contact should be the individual that has either physical custody or educational decisionmaking authority for the child.

Parent/Guardian/Foster Parent: Indicate the relationship of the primary contact to the child. Use one of the following choices:

Father	Grandmother	Legal Guardian
Mother	Grandfather	Educational Surrogate
Stepfather	Aunt	DFS Case Worker
Stepmother	Uncle	
Foster Father	Foster Mother	

In the case where parents live separately, even though both parents may share legal custody, the name of the parent who has physical custody of the child is recorded first and in the second Section, list the other parent. If both parents have legal custody, they both must receive written notice and both are decision makers in the IFSP process.

If the child is a ward of the state and has an Educational Surrogate. information appears under the "primary contact", and the DFS caseworker information should be placed under "other contact information."

Mailing Address: This space is provided to identify when the address used for mailing purposes is different than the residence address (i.e, a P. O. Box).

Home/Street Address: Record the street address of the primary contact.

Telephone: List the day and evening telephone numbers for the primary contact. Make sure to indicate if this is a home (h) or work (w) number. Confirm with the contact the best time to call and which phone number should be used.

E-mail(s): List e-mail address(es), if available.

Native language: Federal regulations require that families be provided information in their native language. Identification of this information will help to ensure that each family's active participation in the IFSP process and procedural safeguards are supported. Ask the family what their **native language** is and record this precisely. Native language means the language or mode of communication normally used by the parent of a child eligible for Part C services. If an interpreter is needed, be sure to indicate this as well.

Other Contact Information

Use this section to list information about other key contact individuals for the child. Additional pages may be used if more space is required to record information for these individuals.

Section 3: Service Coordinator Information

This section is used to record information about the child and family's On-going Service Coordinator. There is also space here to list information about the MC+ Contact Person and the child's Primary Care Physician.

Record the name and contact information of the individual who has been identified as the family's On-going Service Coordinator. This individual is selected by the family to assist them in the implementation, monitoring and evaluation of the IFSP. The Service Coordinator contact information should be reviewed regularly and verified for accuracy at least quarterly. This information may be completed prior to the IFSP meeting, and verified with family members and others early on in the meeting.

If the child has an MC+ Case Manager, this information should be recorded on this page.

List the name and contact information for the child's primary care physician, if known.

Section 4: Child's Present Level of Development--Abilities and Strengths

Purpose: Section 4 lists information about a child's present level of development, including their strengths and abilities in all of the following areas: physical development (including vision, hearing, and health status), cognitive development, communication development, social or emotional development, and adaptive development. Included in this section is any information about health, medical diagnosis and any precautions that must be addressed in activities with the child. <u>All areas of development must be addressed in this Section</u>.

Evaluation and assessments of infants and young children are intended to guide the planning of possible intervention approaches. Evaluation and assessment involve the review of multiple sources of information and assist both parents and professionals in understanding the child's competencies and resources. Assessment should represent an effort to understand infants and young children in the context of their family and of their care giving and learning environments. Scores obtained as a result of test activities are recorded on the Eligibility Determination Documentation and need not be repeated in the IFSP. Rather, the intent of this Section is to provide a narrative statement about the skills and abilities that the child currently demonstrates.

This information is used as a starting point for team discussion and the development of outcomes for the child and family. At each review of the IFSP, this page will be rewritten to reflect up-dated information. All evaluation or assessment reports will be kept in the child's early intervention (EI) record. Evaluation and assessment information should be reviewed with the family before the information is recorded on the IFSP.

<u>Instructions:</u>

Existing information including parent interview, structured observation, medical input, etc., should be used before any additional formal assessments are planned or conducted. In order to avoid unnecessary duplication of activities, it is important that the Intake/Service Coordinator and family members obtain and review relevant information, particularly information recorded on the eligibility determination form.

This form is considered a source document when completing this section of the IFSP and it is not necessary to repeat the information already recorded in the eligibility documentation.

Team Summary: Child's Present Abilities and Strengths: Basic identification information related to the eligible child is included on this page, including the documentation of what the child can do and what the child needs to learn. It is suggested that this Section be developed by the family prior to the IFSP meeting, and reviewed and expanded by the full IFSP Team at the IFSP development meeting. The IFSP Team develops the final language used to complete this Section in the IFSP.

In crafting the language in the Section, it is important to be positive, talking about the skills that the child has and how these are applied in daily living situations. This statement must include all developmental domains, and should indicate emerging skills and interests, skill quality and intent. Comments related to quality and intentions of movement are helpful once the basic skills are defined and discussed. Age equivalents, percent of delay, or standard deviations should not be included in this Section of the IFSP. The developmental domains are: cognition (thinking skills), language and communication, physical (fine and gross motor skills, vision, hearing & health status), adaptive skills such as eating, dressing and bathing, and social/emotional skills including how the child gets along with others.

Information on vision, hearing and health/physical/nutrition status must also be indicated. If there are no concerns in any of these areas denote it by putting "no concern" or "none", **do not leave the section blank**.

Other Strengths/Concerns [optional]: Other information relevant to the development of the IFSP, including birth history, diagnosis, or necessary precautions may be summarized here. Concise descriptions in behavioral, functional or diagnostic terms easily understandable to parents and caregivers should be used. This information should be included if it pertains to service planning or delivery; this Section is not meant to summarize the birth history unnecessarily. Pending surgery, new medications or equipment, health issues, etc., as well as birth and other historical health issues are all appropriate items to include in this Section if they influence the planning and delivery of services.

If there are no other influencing factors for the individual child, record N/A (not applicable) in this Section.

Application of this Section: Prior to the IFSP meeting, the family should be assisted to complete this Section in order to develop, in their own words, a statement of their child's skills in all developmental levels. The family statement would be used during the IFSP Team Meeting to provide the basis for the final summary, which is included in Section 4 of the IFSP.

Section 5: Summary of Family Concerns, Priorities And Resources (CPR) To Enhance The Development Of Their child

Purpose: State and federal regulations provide that, with the family's consent, an assessment of family concerns, priorities and resources (CPR) be conducted prior to the development of the IFSP. For those families that chose to participate in the assessment, this IFSP Section provides a standard method to document or summarize the information gathered during that assessment.

Instructions:

At the top of the page indicate whether or not the family gave their consent to participate in the family assessment. If the family consented to participate, insert the completed form into the IFSP. If the family did not consent, indicate that at the top of the form and leave the form blank.

Section 6: Child and Family Centered Outcomes

Purpose: This Section provides the format for defining individual outcomes related to the child and family's needs. It includes identification of the current status, specific objectives and strategies for addressing and achieving the outcome. State and federal regulations require the IFSP Team to conduct an IFSP review at least every six months to assess the child's progress towards achievement of outcomes and whether modifications or revisions of the outcomes or services is necessary. Evaluation of the entire IFSP is required at least annually.

If the family completes Section 5 of the IFSP (Summary of Family Concerns, Priorities and Resources), the IFSP team needs to consider this information when developing outcome(s).

There will be only one (1) outcome per page. Each outcome will be numbered consecutively.

It is important during the IFSP Team meeting to discuss the provision of service coordination with the entire team and develop specific understanding and strategies that will detail the mutually-agreed upon activities of the Service Coordinator. The routine obligations of the Service Coordinator (monitoring, review and evaluation of the IFSP) as well as other activities that are agreed to be provided by this person, should be reflected either as an outcome in the IFSP, or as a strategy within an outcome.

Instructions:

Outcome: Record a statement here of what the team would like to see happen, and why, for the child &/or the family. The focus of this outcome statement is to clearly describe what difference or change for the family will occur once this outcome is achieved. Language describing the change desired and what this means for the child and/or family is part of the outcome statement.

Strategies and Activities: What are the strategies, activities or next steps that need to occur to achieve the outcome?

This section is optional and can provide a strong basis for making sure the team discusses information gathered from the family about the daily routines of the child and family and the environments in which it makes sense to embed the services. Consider the outcomes that are developed within the context of natural environments and routines identified by this family and document ideas for addressing the outcomes within those routines. What are some strategies for using materials and resources that are already available within those environments and helping find ways to address the identified needs using those naturally occurring resources and supports?

The worksheet "Identifying Typical Family Routines and Activities" that is completed with the family during IFSP planning should be a helpful tool for initiating these discussions about strategies during the IFSP meeting.

Time Line: Indicate when the outcome will be measured for progress by the IFSP team.

Procedure: Indicate how the team plans on measuring progress toward the outcome. The team should state how they will monitor and measure change including observations, report, etc.

Criteria: Indicate what needs to be accomplished for the outcome to be fully met. This should tie back to the outcome in that there will be an observable change to the family and the other team members. This change may be developmental or it may be related to improvements in a daily activity.

Application of this Section: Families should be assisted by their Service Coordinator to develop outcome statements that are important to them before attending the IFSP Team Meeting. By listening carefully to families, the Service Coordinator can help the family to put into words those things that are most meaningful to them. In order for the family to have active and informed participation in the IFSP development meeting, they need to have time and opportunity before the meeting to discuss what they need.

The family should be assisted to come to the IFSP Team meeting with their thoughts on paper, so that they have materials to refer to from time to time during the meeting. This type of preparation is no different than the preparation conducted by various professionals in anticipation of an IFSP meeting. Having a prepared and actively participating family ensures that the family's needs are the primary focus of all IFSP Team members.

Section 7: Early Intervention Services

Purpose: Section 7 of the IFSP is a summary of the services necessary to meet the unique needs of the child and family. Specific information, including the **type** of service, **how often** the service is to be provided, when the service is to begin and for **how long,** must be included in the IFSP document. Also required is information regarding **where** services are delivered, **who** will provide the service and **what funding source** will be used to pay for early intervention services.

State and federal regulations require that, to the maximum extent appropriate, Early Intervention services must be provided in natural environments (e.g., the home, child care centers, or other community settings). Natural environments are defined as those settings that are natural or normal for the child's age peers who have no disabilities. For most infants and toddlers, services will be provided in the Natural Environment. For some infants and toddlers, the appropriate location of services might be another setting—for example, a hospital during the period in which they require extensive medical interventions or a clinic which houses specialized therapy equipment.

When determining the location for the provision of services, it will be helpful if the Service Coordinator has completed the worksheet "Identifying Typical Family Routines and Activities" with the family. By having information of the location(s) in which the child spends his/her day, this will assist the team when they are considering location for the provision of services in natural environments for the child.

Section 7 should be completed only **after** the outcomes and strategies/ activities are identified. The IFSP Team will identify those services necessary to meet the identified outcomes, and will strive to establish the delivery of these services in a natural environment for the child and family. It is the responsibility of the IFSP Team to ensure that each family is fully informed of the services that are **available** under Part C and that those services **identified to be provided** are **allowable** services under Part C and that services are based upon documented need.

Any identified services must have informed, written parental consent prior to their being provided. **Parents may decline any specific service recommended by the IFSP Team without jeopardy to the child's eligibility, or to the other services on the IFSP.** Notations of this discussion should be made in the Intake/Service Coordinator's case notes and maintained in the child's early intervention record.

COMMENT: Specific services may be needed only temporarily or additional outcomes may be identified because of progress made or changes in the family. This document is a tool, a blueprint for services. Often, that blueprint must be modified to meet new challenges or decisions made by the family. The Individualized Family Service Plan can change as often as necessary through the IFSP meeting process. Each additional outcome may identify a need for additional strategies or activities. These can be added when determined necessary by the IFSP team.

Instructions:

Column A: **Outcome(s):** Record the outcome number(s) following #. There may be more than one service per outcome and more than one outcome per service.

Column B: **EI Service(s):** List the identified service(s) that have been agreed upon to address this outcome**.** Early Intervention services may include:

Occupational Therapy	Physical Therapy
Audiological Services	Psychological Services
Special Instruction	Service Coordination*
Health Services	Social Work Services
Medical Diagnostic Services	Speech/Language Therapy
Nursing Services	Transportation**
Nutrition Services	Vision Services

Assistive Technology Devices and Services* *

*Service coordination **must be listed** on **every** IFSP. If the family declines Service Coordination, it is considered to be a refusal of all First Steps services.

** These services must be documented on the applicable authorization forms for these services and then attached to the IFSP. See Section 7a and 7b for additional instructions.

Column C: **Start Date:** Record (m/d/y) when the service will begin. The date must be within the effective dates of the IFSP and should be as soon as possible after the IFSP meeting date.

Column D: **End Date:** Record the end date (m/d/y) for the service, not to exceed 365 days or go beyond the day before the child's third birthday.

Exceptions to this occur when the IFSP covers services for a child under Missouri's "third birthday exceptions." The IFSP under this situation must be developed within the timelines and procedures of the third birthday policies. (See Missouri State Plan for Part C, Transition to Preschool Programs)

Column E: **Provider:** List the name(s) of the person(s) and the agency/independent, as applicable, who will provide the service. Phone number(s) and/or address(es), including e-mail addresses will assist with ongoing communication.

Column F: **Method:** There may be more than one method per service, however only one code can be listed per line on the form. Codes for method of service delivery are:

1 – Consultation/Facilitation with others
Definition/Examples: First Steps providers guide adult caregiver(s) with specific intervention strategies. May also make suggestions for modifications to the environment, develop accommodations, etc. May include consultation with child care provider, visiting a family with another provider, assisting others to prepare for the child's transition to other or new services, etc.

2 – Family Education, Training and Support
Definition/Examples: Specifically planned training designed for family members such as specialized sign language training, a course of study designed especially for parents regarding a specific training technique including behavior management, intervention strategy, disability, etc. The child is typically not present for this service type.

3 – Direct Child Service
Definition/Examples: This includes a direct service provided to the child, typically with a primary caregiver present and observing the interaction. May also include parent training in positioning, language stimulation, etc.

Column G: Indicate whether the service is provided in an individual or group setting. Group settings are only applicable to Special Instruction and Speech therapy services.

Column H: **Location:** Record the specific location from the legend below:
A: Home (child's home, including foster home)
B: Other Family Location (grandparent, aunt, etc.)
C: Community Setting (child/daycare, preschool other than "B" above)
D: Special Purpose Center or Clinic (includes hospital, residential facility, service provider location, & "other")
There can be more than one location per service, however, each location needs to be recorded on a separate line on the form.

Column I: **Frequency:** Record the agreed upon number of days or sessions and indicate whether this frequency is by the week (WK) or month (MO).

Column J: **Intensity:** Record the length of time that the service is to be provided (e.g. "30 minute session"). Do not use descriptors such as "as needed" or "to be determined."

Column K: **Funding Source:** Insert the code letter for the funding source which is to be used or billed for the service.
A: Central Finance Office (CFO) (First Steps, Title V (Medicaid))
B: DMH/MRDD for service coordination provided by this agency

Column L: **Initial/Revision/Addition:** Indicate if this is an initial service a service that is being revised or a service that is being added.

Primary Setting for this IFSP:
The IFSP Team must identify a primary setting where IFSP services will be provided. Once all of the services have been identified, the Team reviews the various strategies and settings and determines which one of the following settings most accurately defines where the majority of services will be provided. This consideration includes looking at the frequency and intensity of all services in addition to the specific location codes. Circle the one determined to be the primary setting. Setting options are:

1. Special purpose facility: program designed specifically for children with developmental delays or disabilities.
2. Community setting: program designed primarily for typically developing children. Includes childcare settings, preschools, and other community programs.
3. Home: In addition to the child's own home, this may include the provision of service in a relative's home.
4. Hospital: Refers to inpatient services only.
5. Residential facility
6. Service provider location: This location would include a clinic or provider's office where the family receives service.
7. Other setting: Use the actual location descriptor.

Section 7a. Assistive Technology (AT) Authorization

IFSP Meeting Date: Enter the date of the IFSP meeting in which the need for specific AT was discussed.

IFSP Outcome Number: List the IFSP outcome number(s) for which the AT service has been determined necessary by the IFSP team.

Start Date: List the start date for this service.

End Date: List the end date for this service.

Provider: Enter the name of the provider of this service.

HCPCS Code: Fill in the appropriate HCPCS code for the item to be purchased.
Description of Item: Fill in the description of the item that corresponds to the HCPCS code.

Type: Indicate whether the item is to be purchased, rented, or repaired.

Quantity: Indicate the number of item(s) to be purchased.

Price: Enter the cost of the item in dollars and cents. If purchasing more than one item, fill in the unit cost per item.

Section 7b. Transportation Authorization

Start Date: Fill in the start date for transportation.

End Date: Fill in the end date for transportation.

Provider: Indicate the name of the provider who will be providing the service.

Frequency: Indicate the number of trips per authorization, week, month, or year.

Maximum Miles Per Trip: Indicate the maximum number of miles per trip.

Section 8: Natural Environments Justification

Purpose:

The Natural Environments (NE) Justification form must be completed once the IFSP services have been identified, **if all or any of the services will not be provided in a Natural Environment.** A justification must be completed for **each** service that is being provided **outside** of the natural environment. If all services are being provided in Natural Environments, this section will not need to be completed. This page may also be reproduced if needed.

Instructions:

Outcome#: Write the outcome number from Section 7 for which you have identified a service that will be provided outside of the natural environment.

Service: Indicate which service was identified in the outcome as being provided outside of the natural environment.

Environment: State the specific location identified for the provision of the service (see Section 7, Column H).

Justification: Explain why the IFSP Team determined that it was not appropriate to provide this service in a natural environment. This explanation should describe what the IFSP Team discussed to make the determination that it was necessary to provide early intervention services in a setting other than a natural environment and how it was determined that the selected environment would more effectively facilitate achievement of this outcome.

Section 9: Other Services

Purpose: This Section provides the opportunity for the IFSP Team to review any other services identified as necessary to meet child and family outcomes. These other services, while not required or eligible under Part C, are responsive to overall child and family needs (e.g. in-home support, respite care, medical equipment, etc.) The IFSP must include specific information about these services, ensuring that consideration has been given to all potential sources and strategies to support the family's identified outcomes, however, **there is no obligation of the Part C system to fund these services.**

Section 9 encourages the identification of other family support services as well as preventive medical and health services for the eligible child and family. These services may include those identified through the family assessment of concerns, priorities and resources (Section 5) or reflect services that support the family in areas beyond the early intervention system. The Service Coordinator works with the family members to monitor the delivery and evaluation of these services on a routine basis.

Instructions:

Service(s): Record here the name of the service.

Family/Child Service: Depending upon who the service is provided to, circle family or child.

Responsible Individual: Write in the name of the person or agency who will provide this service.

Funding Source: Indicate the funding source to pay for this service. Possible funding sources for these services are: Medicaid, private insurance, other federal, state and local disability funds, etc. **Part C cannot be indicated here as a possible funding source**.

Section 10: Transition WorkSheet

Purpose:

Transition planning is a component of each IFSP development, review or evaluation activity, and it is conducted to ensure that services continue to be provided without unnecessary interruption. Transition planning also helps to ensure that the child and/or family will experience success and benefit from the planned services by preparing them appropriately for any changes.

State and federal regulations require that IFSP teams plan for a child's transition out of the Part C (First Steps) system at age three. Each IFSP, must include documentation of the steps to be taken to support that transition, whether that transition will be to preschool services under Part B (Early Childhood Special Education) or to other services that may be available, such as Parents as Teachers, Head Start, Title I Preschool programs, etc. Then, at least six months prior to the child's third birthday a Transition IFSP meeting must be held to discuss this transition and to document the steps needed to accomplish a smooth and effective transition.

Transition planning for the infant or very young toddler will often involve introducing the parents to information about the transition process and the choices that will occur when the child approaches age three. For the older toddler, the transition planning becomes more specific.

It should be noted that while IDEA requires specific procedures for transition in relation to the changes that occur for the child and the family at the child's third birthday, it is also good practice to consider other transitions that occur not only as the child moves from the system, but also into and within the system (hospitalizations, changes of service provider, family moves, movement from the hospital to home, the anticipation of surgery for the young child, the addition of new medications or technology, family issues such as employment, the birth of a new child, etc.). Planning for these other transitions should be documented in the IFSP along with the required documentation of the transition planning related to exiting First Steps at age three.

Instructions:

Specific Transition Issue: The transition points in the left hand column serve as reminders or "prompts" to the family and IFSP Team as to the variety of transitions that may occur for a child and family. Transitions have been divided into two sections ("Into and Within" and "Transition From") First Steps. Note that Items 1-8 in the section "Transition into and within" are optional. It is good practice that these areas be considered, but they are not requirements. Items 9 and 10 in the "Transition from (age 2.5 years)" are **required items** to be completed at each IFSP review. Items 11 and 12 would be completed, as appropriate, to facilitate the child's transition to ECSE or other programs at age three, with the parent's consent.

Who is Responsible: The IFSP Team member assigned to follow-through on the specific issue should be identified here.

Effective practice is for transition needs to be incorporated into the IFSP as relevant to the provision of IFSP service(s) or if the transition is defined by the parent as significant. Under these circumstances, transition planning needs may be extended into at least one (1) outcome statement in the IFSP, with detail provided as to the strategies and activities planned to achieve successful transition OR these needs may be incorporated as a strategy or activity within an existing Outcome.

While other transitions may occur, they may not be of the nature or consequence that the family or remainder of the IFSP Team feels will influence the successful implementation of the IFSP.

For example, the termination of a service for one family may not require any transition planning; for another family, it may be important to plan for the gradual reduction of services depending upon the individual child and family needs. For some children, the change of provider may be significant and require considerable transition planning. Teams should use good judgment in delineating the significance of transitions on an individualized basis and incorporate these issues into the IFSP appropriately.

Application of this Section: This Section should be developed in advance of the IFSP Team meeting with the family and serves as a discussion and planning point for the entire Team.

Section 11: IFSP Development Team and Contributors

Purpose: This Section lists information about the people who participated in or contributed to the IFSP development, including those who conducted evaluation or assessments but did not attend the IFSP meeting.

Each initial meeting and each annual meeting must include the following:

1. The parent(s) of the child
2. Other family members, as requested by the parent, if feasible to do so
3. An advocate or person outside of the family, if the parent requests that the person participate
4. The Intake &/or On-going Service Coordinator
5. A person or persons directly involved in conducting the evaluations and assessments of the child
6. As appropriate, persons who will be providing services to the child or family

If the person or persons involved in conducting the evaluations and assessments of the child (#5 above) is unable to attend the IFSP meeting, arrangements must be made for the person's involvement through other means including telephone conference call, having a knowledgeable authorized representative attend the meeting, or making pertinent records available at the meeting.

For each periodic review of the IFSP, the individuals indicated in #1-4 above must be in attendance and, if conditions warrant, provisions must be made for the attendance of those individuals listed in #5 & #6.

Instructions:

Name: Record all individuals who have participated in the development of the IFSP. Include name, role, agency, and phone number.

Method of Participation:
Define the method of participation of the team members. The member's signature reflects their attendance at the IFSP Team meeting. In the case of an initial IFSP or annual IFSP review, if an individual involved in conducting an evaluation/assessment of the child was not present, the Intake/Service Coordinator must designate the method of participation for that individual, such as "submitted written report," "provided verbal recommendations," "conference call," "sent representative," etc. If that person sent an authorized representative, the representative should list their name and indicate after their signature who they are representing.

How will this team keep in touch? How often?
Before formally ending the IFSP Team meeting, team members should discuss the frequency and method for keeping in touch with one another, including plans for routine correspondence, telephone calls, and progress reports. This is also an excellent time to schedule the six-month review date with the Team.

Section 12: IFSP Review and Early Intervention Service Revisions

Purpose: This provides a format to document changes/updates to the IFSP. The IFSP will require modification because it is an evolving document that changes as the child and family needs change. This form will only be used for six-month or interperiodic reviews.

The review of an outcome may be prompted by an expressed need by a team member, including the family, to change an existing service. Concurrently, in reviewing an outcome, the IFSP Team may decide that revisions in service delivery must be made in order to successfully make progress on the outcome. Once this outcome review is conducted indicating the direction for change in service, the Review Section must be completed indicating the service to be modified and the particulars (such as termination, addition, or change in frequency, location, duration, intensity).

IFSP Review
Instructions:

Review Cycle: Fill in the box in front of the type of review that is occurring, either six-month or interperiodic.

Outcome #: List outcome number from IFSP.

Progress Summary: Record parents and providers' overall conclusions based on the review and references to outcomes from the current IFSP.

Team Evaluation: Insert the appropriate numbers from the Team Evaluation Scale to indicate the team's corresponding assessment of the situation.

Modifications/Revisions: Record parents' and providers' changes in ideas and activities, or circumstances, which will impact outcomes.

In addition to completing this form, any changes to an IFSP must be applied to each Section of the IFSP that requires revision. Once all revisions are made to the pertinent sections, the remainder of the IFSP document left unchanged may be photocopied. If Section 7 requires revisions make needed changes to that section and mark the changes in column L as a revision or addition. For revisions, the documents that will be required are as follows: a new cover page (indicating date and type of meeting), Section 12, and the photocopied IFSP with any new sections. Each IFSP must be reviewed at least six months after initial development. The development of an inter-periodic IFSP will not result in a new date for annual IFSP. This entire IFSP document needs to be provided to all IFSP Team members including the family; the original is filed with the SPOE in the EI Record.

If the only changes required are provider name and/or funding sources, make the change directly on the current Section 7 of the IFSP by crossing out the old information and adding the correct information and current date. The Service Coordinator sends a copy of this page to the SPOE. **All other changes – e.g. frequency, intensity, location etc. require an IFSP team meeting and documentation as shown above under Modifications/Revisions**. **This is the only exception to the rule that IFSP revisions require an IFSP team meeting.**

The IFSP is assembled as earlier discussed, with the cover page first followed by the modifications pages. The Sections of the IFSP that have been changed are integrated with copies of the other Sections that remain unchanged. All of these pages constitute the revised IFSP which is then copied and distributed to all IFSP Team members; the original document is maintained at the SPOE in the EI Record.

Child's Name: _____ Date: _____

Section 2: FAMILY INFORMATION

*Primary Contact: _____

*Relationship to child: _____

*Mailing Address: _____

*City/Town: _____*State: _____*Zip: _____

*Home/Street Address: _____

*Day Phone: _____ (h___ w___)
*Evening Phone: _____ (h___ w___)
*Best time to call: _____
E-mail: _____
Other way to contact: _____
*Native language:_____
*Interpreter Needed? Yes No

OTHER CONTACT INFORMATION:
*Name: _____

*Relationship to child: _____

*Mailing Address: _____

*City/Town: _____*State: _____*Zip: _____
*Home/Street Address:_____
*Day Phone: _____ (h___ w___)
*Evening Phone: _____ (h___ w___)
*Best time to call: _____
E-mail: _____

Section 3. SERVICE COORDINATOR CONTACT INFORMATION

*Name: _____

*Agency: _____

*Work Telephone: _____

*Cell Phone: _____

*Best time to call: _____

*FAX: _____

*E-mail address: _____

Mailing Address: _____

City/Town: _____

*State: _____ *Zip: _____

*MC+/Plan Contact Person : _____

*Telephone:_____ *FAX Number: _____

*Physician: _____

*Address: _____

*City/Town: _____, State: _____ Zip: _____

Telephone: _____ FAX:_____

E-mail: _____

Child's Name: _____ Date: _____

Section 4: CHILD'S PRESENT ABILITIES AND STRENGTHS: TEAM SUMMARY.

WHAT MY CHILD CAN DO NOW - INTERESTS, MOTIVATORS, NEW SKILLS, THINGS TO CELEBRATE, WHAT MY CHILD IS READY TO DO, WHAT'S WORKING WELL. Make sure that all developmental domains are included. Describe in an integrated, functional manner how this child: does things for him/herself (Adaptive/Self Help Skills); how s/he problem solves and plays (Cognition); how s/he uses hands, oral motor skills, how s/he moves around (Physical Skills); how s/he indicates understanding, wants, and needs (Communication Skills); and how s/he shows feelings, copes with frustration or stimulation, and gets along with others (Social/Emotional Skills).

Adaptive Self Help:

Cognition:

Physical:

Communication:

Social/Emotional:

Vision / Hearing:

Health/Physical/Nutrition Status:

Other Strengths/Concerns including relevant information (medical diagnosis, birth history, health status, sensory issues, etc.) or other concerns, which might affect service delivery.

Child's Name: _____ Date: _____

Section 5. SUMMARY OF FAMILY CONCERNS, PRIORITIES AND RESOURCES TO ENHANCE THE DEVELOPMENT OF THEIR CHILD

Family declined consent to complete an assessment of family concerns, priorities and resources: Yes No (If "yes" leave this section blank, If "no" this section must be completed.)

I have questions about or want help for my child in the following areas:

- ☐ Moving around (crawling, scooting, rolling, walking)
- ☐ Ability to maintain positions for play
- ☐ Talking and listening
- ☐ Thinking, learning, playing with toys
- ☐ Feeding, eating, nutrition
- ☐ Having fun with other children; getting along
- ☐ Behaviors and feelings
- ☐ Toileting; getting dressed; bedtime; other daily routines
- ☐ Helping my child calm down, quiet down
- ☐ Pain or discomfort
- ☐ Special health care needs
- ☐ Seeing or hearing
- ☐ Other: _____

I would like to share the following concerns and priorities for myself, other family members, or my child:

- ☐ Finding or working with doctors or other specialists
- ☐ How different services work or how they could work better for my family
- ☐ Planning for the future; what to expect
- ☐ Parenting skills
- ☐ People who can help me at home or care for my child so I/we can have a break; respite or child care
- ☐ Housing, clothing, jobs, food, or telephone
- ☐ Information on my child's special needs, and what it means
- ☐ Ideas for brothers, sisters, friends, extended family
- ☐ Money for extra costs of my child's special needs
- ☐ Linking with a parent network to meet other families or share information
- ☐ Other: _____

FAMILY'S CONCERNS ABOUT THEIR CHILD

PRIORITIES OF THE FAMILY (Select from items checked to the left)

STRENGTHS, RESOURCES THAT OUR FAMILY HAS TO MEET OUR CHILD'S NEEDS

Child's Name: _____ Date: _____

Section 6. FAMILY AND CHILD CENTERED OUTCOME(S) **This page should be duplicated as needed**

Outcome # _____:

Optional: Strategies and Activities: (Summarize ideas for addressing the outcome within the child and family's naturally occurring routines and environments using people and materials that are available there. This is not a listing of early intervention services)

When will we as a team measure progress towards this outcome? (timeline)

How will we, as a team, measure progress towards this Outcome? (procedure)

Our team will be satisfied we are finished with this Outcome when: (criteria)

Child's Name: _____ Date: _____

Section 7. *EARLY INTERVENTION RESOURCES, SUPPORTS AND SERVICES This entire page is part of electronic record.

Column A	Col. B	Column C	Column D	Col. E	Col. F	Col. G	Col. H	Col. I	Col. J	Col. K	Col. L
Outcome(s) #	Early Intervention Service(s)	Start Date	End Date	Provider(s) Name	Method (see below)	Ind. Or Group	Location (see below)	Frequency	Intensity	Funding Source	Initial (I) Addition (A) Revision (R)
#											
#											
#											
#											

1) Column F, Method Code: 1 = Consultation/Facilitation with Others; 2 = Family Education/Training/Support; 3 = Direct Child Service
2) Column H, Location Code: 1 = Home; 2 = Other Family Location; 3 = Community Setting; 4 = Special Purpose Center or Clinic

Primary Setting for this IFSP: (circle) special purpose facility - community setting - home - hospital - residential facility - service provider location - other setting

Child's Name_____ Date:_____

***Section 7a. Assistive Technology Authorization – IFSP Meeting Date:_____**

IFSP Outcome #	Start Date	End Date	Provider	HCPCS Code	Description of Item	• Purchase • Rental • Repair	Quantity	Price	Remarks (Optional)

***Section 7b. Transportation Authorization**

IFSP Outcome #	Start Date	End Date	Provider	Frequency	Maximum miles per trip

Child's Name_____ Date:_____

***Section 7a. Assistive Technology Authorization – IFSP Meeting Date:_____**

IFSP Outcome #	Start Date	End Date	Provider	HCPCS Code	Description of Item	• Purchase • Rental • Repair	Quantity	Price	Remarks (Optional)

***Section 7b. Transportation Authorization**

IFSP Outcome #	Start Date	End Date	Provider	Frequency	Maximum miles per trip

Child's Name: _____ Date: _____

Section 8: Natural Environments Justification

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Child's Name _____ Date: _____

Section 9: * Other Services **This entire section is part of the electronic record.**

Service	Family or Child Service	Responsible Individual	Fund Source
	family / child		
	family / child		
	family / child		
	family / child		
	family / child		

Child's Name: _____ Date: _____

Section 10: Transition Checklist

Transition Activities into, within and from First Steps: Identification of activities and responsible individuals to assist the family and child with transitions include:	Specific Transition Issue	Who is responsible
Transition into and within: (Optional)		
1. Transition from hospital, neonatal intensive care unit to home, and into early intervention services to ensure that no disruption occurs in necessary services		
2. Family related changes that may affect IFSP service delivery i.e., employment, birth or adoption of sibling, medical needs of other family members)		
3. Child related changes that may affect IFSP service delivery (i.e., hospitalization or surgery, placement in a child care program, addition of new equipment or technology, medication changes)		
4. Introduction of new or a change in: Service Provider (s) Service location (s)		
5. Termination of existing IFSP service		
6. Explore community program options for our: Child Family		
7. Child and Family exiting First Steps system due to Loss of eligibility Family does not consent to participate		
8. Other Transition		
Comments:		
Transition from (age 2.5 years): 9 & 10 required at each IFSP Meeting		
9. **Discussion** with, and training of parents regarding future placements and other matters related to the child's transition		
10. **Discussion** about procedures to prepare the child for changes in service delivery including steps to help the child adjust and function in a new setting		
11. **Send** with parental consent, information about the child to the local education agency to ensure continuity of services including evaluation and assessment of information and IFSP's		
12. **Send** specified information to community programs, upon informed, written consent, to facilitate service delivery or transition from the First Steps early intervention system		
Comments		

Child's Name:_____ Date:_____

Section 11: IFSP DEVELOPMENT TEAM AND CONTRIBUTORS

Printed Name	Position/Role	Agency (if applicable)	Telephone	Signature or Method of Participation

How will this team keep in touch? How often?

Child's Name _____ Current IFSP Date: _____ Revision Date _____

Section 12: IFSP Review Documentation Worksheet

☐ 6 Month Review ☐ Interperiodic Review

Team Evaluation Scales: 1= Situation changed: outcome not needed, 2= Situation unchanged; still need outcome, 3= Outcome partially attained, 4 = Outcome accomplished

Outcome #	Progress Summary	Team Evaluation	Modifications/Revisions

IFSP Follow-Up

1. Physician Summary Form
2. Physician Summary Instructions
3. Provider/Service Coordinator Documentation Guidelines
4. Service Coordinator Case Notes
5. Service Provider Daily Progress Report
6. Service Provider Monthly Progress Report
7. First Steps Change of Information and Inactivation Form

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)
PHYSICIAN SUMMARY

Missouri First steps EARLY INTERVENTION

Child's Name:		
Date of Birth:	IFSP Date:	
If you have any questions, please call: Service Coordinator Name:		
Telephone:	FAX:	
Social/Emotional Skills	Present Level of Functioning:	
	Outcome(s):	
	Recommended Intervention (Type, Frequency, Intensity)	
	Provider:	Telephone:
Cognitive Skills	Present Level of Functioning:	
	Outcome(s):	
	Recommended Intervention (Type, Frequency, Intensity)	
	Provider:	Telephone:
Communication Skills	Present Level of Functioning:	
	Outcome(s):	
	Recommended Intervention (Type, Frequency, Intensity)	
	Provider:	Telephone:

Gross Motor Skills	Present Level of Functioning:	
	Outcome(s):	
	Recommended Intervention (Type, Frequency, Intensity)	
	Provider:	Telephone:
Fine Motor Skills	Present Level of Functioning:	
	Outcome(s):	
	Recommended Intervention (Type, Frequency, Intensity)	
	Provider:	Telephone:
Vision/Hearing Skills	Present Level of Functioning:	
	Outcome(s):	
	Recommended Intervention (Type, Frequency, Intensity)	
	Provider:	Telephone:
Other Areas	Present Level of Functioning:	
	Outcome(s):	
	Recommended Intervention (Type, Frequency, Intensity)	
	Provider:	Telephone:
COMMENT:		

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)
PHYSICIAN SUMMARY
INSTRUCTIONS

This form is to be completed by the Intake/Service Coordinator when a new IFSP is developed, or when there are changes to the IFSP for an individual child. It is intended to provide a concise IFSP update for the child's medical care providers, as well as specialty providers. The information in this Summary is to be based upon the IFSP and other source documents, and should be clearly legible, concise, factual and informative. This Summary should be completed as soon as possible following the IFSP meeting and sent to the family and the child's medical care provider(s). This Summary may also be sent to other providers as requested by the family.

This Summary is meant to take the place of reproducing and sending the IFSP unnecessarily. As always, it is important to make sure that the child's medical care providers are fully informed which may mean that some of these individuals will want to receive a copy of the full IFSP. In this instance, it is not then necessary to also prepare and send a Physician Summary to that individual.

Child's Name:	
Date of Birth:	IFSP Date:
If you have any questions, please call: Service Coordinator Name:	
Telephone:	FAX:

Skill Area		
	Present Level of Functioning: *The Service Coordinator should review the Eligibility Determination documentation as well as the Statement of Performance from the IFSP in developing a brief, positively oriented statement describing the child's current level of functioning in all developmental domains.*	
	Outcome(s): *If there is an Outcome(s) related to a specific skill area, it should be recorded here.*	
	Recommended Intervention (Type, Frequency, Intensity) *If there is a service(s) related to this skill area as a result of an Outcome, please list the service with the frequency, intensity and other important information in this Section.*	
	Provider: *NAME of the Provider*	Telephone: *Provider Telephone Number*

COMMENT:

Provide additional information as needed.

PROVIDER/SERVICE COORDINATOR DOCUMENTATION GUIDELINES

Effective documentation is critical in the early intervention process. It serves as a blueprint for service provision as well as a means for accountability. Because the IFSP must be reviewed every 6 months, effective documentation will assist the service coordinator in completing this review successfully. Since service coordinators and parents will use this documentation, it must provide all relevant facts in an organized manner (Dunn, 1991).

In the role of communication, documentation must be efficient and effective. To do this best, one must consider the intended audience (Dunn, 2000; McGuire, 1997). Because the primary audience in First Steps is the family, it is important to use person-first language, avoid jargon, be respectful, and relate comments back to performance concerns.

A progress note is defined as a document used periodically to specify care coordination, interventions, and progress toward functional outcomes, update outcomes, and review the individual clinical plan in general. The American Occupational Therapy Association (AOTA) outlines the following as content:

1. Activities, techniques, and modalities used
2. Consumer's progress
3. Goal continuance
4. Goal modification when indicated by the response to therapy or by the establishment of new consumer needs
5. Change in anticipated time to achieve goals
6. Consumer-related conferences and communication
7. Home programs
8. Plan

It is important that a progress note focus on function, underlying causes, state expectations for progress, and explain slow progress/lack of progress (McGuire, 1997). Short-term objectives are more sensitive to relatively small gains toward the long-term goal. It is also valuable for detecting in a timely manner when a program needs modifying. It is up to a therapist, team, and family to determine a hypothesis for what is serving as a barrier for functioning, and how this information this will drive the short-term objectives (Dunn, 1991).

A simple guideline for ensuring good documentation is known as RUMBA, where R=Relevant, U=Understandable, M=Measurable, B=Behavioral, and A=Achievable. Documentation can be a daunting and challenging task. Providing the right support through a solid documentation format will facilitate best practices and support service providers in accomplishing best practices, and this will promote quality care for infants and toddlers. Ultimately, this is the intent of IDEA '97, Part C.

Medicaid requirements for documentation:

Recipient's complete name
Date service was provided
Actual treatment provided on the date of service (detailed)
Actual time service was delivered
Copy of IFSP/Physician IFSP Summary requiring services

Purpose of documentation:

1. Provide a chronological record of the consumer's condition, which details the complete course of therapeutic intervention.
2. Facilitate communication among professionals and with family.
3. Provide an objective basis to determine the appropriateness, effectiveness, and necessity of therapeutic intervention.
4. Reflect practitioner's reasoning.

Provider Progress Reports:

The Service Provider Daily Progress Report represents the provider's contact summary that documents the individual service contacts. This is retained in the provider's clinical record for each child and is not sent to the Service Coordinator. First Steps has created a form that providers can use for this purpose, or the provider may choose to use a different format that captures the same information. Therefore, **this form is optional.**

All providers should maintain daily progress reports for all children served in the First Steps system. This documentation is required for audit purposes by the various funding sources utilized by the First Steps system. If no contact was scheduled for the period, there is no need to submit a progress report. If contact was scheduled and did not occur, a progress report should be completed.

The Service Provider Monthly Progress Report is completed by the provider and sent to the Service Coordinator on a monthly basis, the specific due date to be mutually determined at the IFSP team meeting. This one-page form summarizes the progress made on individual IFSP Outcome(s) that the provider is working on with the family and others. The individual provider reviews the progress report with the family and obtains their signature to document that the review has occurred. If the progress is communicated to the family by telephone or other means, the provider will document this when completing the progress report in lieu of parent signature.

The family and the family's Service Coordinator will be provided a copy of each monthly progress report by the provider. The Service Coordinator is responsible to review these progress reports and to work with the family and individual provider(s) should problems arise, or if the IFSP needs an interperiodic review. The monthly progress report is forwarded to the SPOE by the Service Coordinator

for inclusion in the child's EI record. Service Coordinators should ask about progress on "other" services, but they are not required to track or collect formal progress reports about these "other" services

A template for the Monthly Progress Report is provided by First Steps and must be used by all providers.

The Service Coordinator Case Note represents a summary of each contact (phone calls, meetings, letters, etc.) the service coordinator has with the family, provider, SPOE, etc. that directly relates to the child.

Importance of Case Notes for IFSP Team meetings:

These case notes provide the opportunity to capture discussion and relevant items **that are not** contained or reflected in the IFSP, but may be important for future consideration or documentation. The case notes are the appropriate place to document such items as:

- areas of disagreement, or recommendations that were not reflected in the final IFSP
- parent participation and lack of agreement to services that were recommended but not consented to by the parent/legal guardian

Case notes are maintained in the SC clinical file (copy) and originals are forwarded to the SPOE on a quarterly basis. The quarter begins the month of the Initial IFSP. A case note is the service coordinators documentation of contact for routine monitoring and audit purposes.

A case note format is provided by First Steps and is a required form. (Note: The DMH's current logging system is used in place of this template).

Missouri First steps EARLY INTERVENTION

Service Coordinator Case Note

Child's Name: Date of Birth:

Date	Time	Method of Contact	Person (s)
Topic:			
Follow – up:			
Service Coordinator's Signature:			

Child's Name: Date of Birth:

Date	Time	Method of Contact	Person (s)
Topic:			
Follow – up:			
Service Coordinator's Signature:			

Service Provider Daily Progress Report (Optional)

Child's Name:	DOB:	Provider

Daily Summary/Progress Towards Outcomes(s):

Date/Time					
Units/Code*					
Outcome/Objective	Progress	Progress	Progress	Progress	Progress
Provider Signature					

Additional Comments:

_____

_____

_____

*CODES:

A: Consultation/Facilitation B: Family Education, Training and Support C: Direct Child Service E: Evaluation/Assessment X: IFSP Team Meeting

SERVICE PROVIDER MONTHLY PROGRESS REPORT

Child's Name:	DOB:	Date:

Service Coordinator:

Monthly Progress Towards Outcomes(s):

Outcome #	Progress Summary	Evaluation Scale*	Family and Provider Comments
Family Changes			
Medical Changes			
Comments			

*Evaluation Scale: 1=Situation changed; outcome not needed, 2= Situation unchanged; still need outcome, 3=Outcome partially attained, 4=Outcome Accomplished

_____ _____

Parent/Guardian/Foster Parent/Educational Surrogate Signature Date

Service Provider Signature Date

First Steps Change of Information and Inactivation Form

Completed By:	**Effective Date: / /**

Current Enrollment Information:

Child's Name: _____DOB:_____/_____/_____
Last First MI

☐**ADD** ☐ **CHANGE**

(Software Intake tab, p.1)

☐ Child's Name:_____
Last First MI

☐ Address: _____
Street City State Zip Code

☐ Address: _____
County School District

☐ Phone Number: _____
Person/Location (Area Code) Phone Number

(Software Intake tab, p.3)

☐ Ongoing Service Coordinator: _____

(Software Family tab)

☐ Household Member/Information: _____
Person (Describe Change)

(Software Diagnosis tab)

☐ Diagnosis: _____

☐ Other: _____

Status Change:

(Software Intake tab, p.1)

☐ Child has been found eligible for ECSE services and will receive First Steps services through the summer until _____/ _____/ _____ (date school begins)

(Software Intake tab, p.3)

Inactivation Date: _____/_____/ _____

Inactivation Reason:

☐ Completion of IFSP Prior to Reaching Maximum Age for Part C
☐ Moved Out of State
☐ Moved to Another SPOE (Please list) _____
☐ Withdrawal by Parent/Guardian
☐ Child Deceased
☐ Unable to Contact/Locate by Service Coordinator
☐ Transition to Part B (Transition to Early Childhood Special Education)
☐ Eligible for Part B (Part B Eligibility Determination in Process)
☐ Refused (Part B Eligibility Determination Process Refused by Parent/Guardian)
☐ Part B Ineligible, Exit to Other Programs
☐ Part B Ineligible, Exit with no Referral

RELEASE, CONSENTS AND NOTICES

1. Release of Information Form and Instructions
2. Notice of Action Form
3. Notice of Action Instructions

FIRST STEPS EARLY INTERVENTION SYSTEM
RELEASE OF INFORMATION

I, _____,
Parent/Legal Guardian Name

give my informed consent for:

_____
Individual/Agency Name

_____
Address/Phone Number

to share information with the First Steps Early Intervention Service System regarding

_____, _____
Child's Legal Name D.O.B.

The purpose of the requested information is to determine eligibility &/or to ensure the development of an IFSP and provision of Early Intervention Services by the Missouri First Steps system.

This consent includes the following types of information: (as checked v)

_____ Any and all health/medical/dental records
_____ Any and all assessment/evaluation records/reports
_____ Other: _____

The requested information should be sent to:

_____
Individual/Agency Name

_____
Street Address

_____
City State Zip Code

I understand this consent is effective for a period of twelve (12) months from the date of my signature unless I revoke consent prior to the end of that period. I further understand that any information received through this release will be maintained in my child's Early Intervention record by the Missouri First Steps System in accordance with state and federal regulations implementing the Family Educational Rights and Privacy Act (FERPA) and the Individuals with Disabilities Education Act (IDEA).

_____ _____
Signature (Parent/Legal Guardian) Date

Missouri First Steps
Release of Information

Instructions for Completion

First Steps Intake and Service Coordinators often need to request information to assist in making eligibility determinations, planning for the development of the IFSP, and/or providing early intervention services. The Family Educational Rights and Privacy Act (FERPA), incorporated by reference in the Individuals with Disabilities Education Act (IDEA), requires that the parent's signed and dated written consent be obtained in order for the First Steps System to receive medical and educational information from individuals and agencies outside of the First Steps system in order for the First Steps system

A Release of Information form should be completed for each individual/agency from which it has been determined information needs to be obtained. Please note that this release is ONLY for individuals/agencies OUTSIDE of the First Steps System from whom information needs to be obtained. FERPA does not require that parental consent be obtained in order for those individuals within the system (SPOE staff, the child's Service Coordinator(s), the child's Service Provider(s), the CFO, the DESE) to share information with one another.

Generally, consent is valid for 12 months from the date of the parent's signature. However, the parent may revoke their consent at any time. Should this be the case, the date of the request to revoke the consent should be documented on each consent form to which it applies.

All information obtained from the Individual/Agency listed on the consent becomes part of the child's Early Intervention Record and shall be maintained in accordance with state and federal regulations implementing FERPA and IDEA.

<u>To complete</u>:

- Enter the name of the parent/legal guardian giving consent. Only one parent needs to sign.
- Enter the name/address/phone number of the Individual and/or Agency from whom you are requesting information
- Enter the child's legal name and Date of Birth
- Indicate by placing a check in front of all of the types of records/information that you are requesting. If "other" specifically identify what information you are requesting
- Indicate the name of the individual and/or agency & address where the records/information should be sent
- Have the parent sign and date (m/d/y)

NOTICE OF ACTION

In accordance with Part C of the IDEA

Child's Name : _____Date of Birth: _____Date: _____

Prior Written Notice must be given to you before certain actions are taken. The following is to inform you of the action(s) ? Proposed or ? Refused.

( ) Initial evaluation/assessment* ( ) Change in placement (primary setting)
( ) Ineligibility for First Steps ( ) Change in eligibility
( ) Ongoing evaluation/assessment ( ) Initiation of Early Intervention Service(s)*
( ) Family Assessment * ( ) Other: (Specify) _____

*Parental consent required

Reasons for the Action:

A copy of the Parent's Rights Statement is enclosed with this notice.

If you need assistance in understanding the provisions of the Parent's Rights Statement, you may contact the Special Education Compliance Section, Department of Elementary and Secondary Education at (573) 751-0699 or (573) 751-0186 or via e-mail at webreplyspeco@mail.dese.state.mo.us.

If you have any questions or object to this action, please contact me within 10 days.

_____ _____ _____

Name Title Phone Number

Section 1

PARENT SIGNATURE FOR CONSENT IS REQUIRED before the following actions can be initiated:

Initial evaluation / assessment of the child	☐ Consent	☐ Decline
Family Assessment *	☐ Consent	☐ Decline
Early Intervention Service(s)	☐ Consent	☐ Decline

_____ _____

Parent Signature Date of Parent Signature

Date signed consent received by agency _____

*Family assessment is voluntary. If you decline to participate in the Family Assessment it will in no way affect your child's eligibility for Early Intervention Services.

Section 2

(For any actions not requiring consent)

I understand that the action being proposed cannot be carried out for ten days from the date of the Notice, unless I waive that time requirement.

☐ I would like for the proposed action to be carried out and waive the 10-day time requirement.

_____ _____

Parent Signature Date

Date received by agency_____

Notice of Action Form Instructions

REQUIREMENTS

Prior Written Notice

Written prior notice must be given to the parents of a child eligible under Part C in a reasonable time before a public agency or service provider proposes, or refuses, to initiate or change the identification, evaluation, or placement of the child, or the provision of appropriate early intervention services to the child or the child's family.

Informed Parental Consent

Written parental consent must be obtained before

- Conducting the initial evaluation and assessment of a child under Sec. 303.322 (this includes the family assessment)
- Initiating the provision of early intervention services.

IMPLEMENTATION IN FIRST STEPS SYSTEM

Provision of Written Notice with Consent for Initial Evaluation/Assessment

Before initiating any activities in relation to the initial evaluation/assessment of the child or the Family Assessment, the Service Coordinator must provide the parent with a Written Notice informing the parent of the

- The action(s) proposed
- The reason for the action

On the Notice of Action form, the service coordinator would check in front of the space for (✓) Initial evaluation/assessment and then for (✓) Family Assessment.

Under "Reasons for the Action" the Intake Service Coordinator would indicate the specific reason (s) for the action. In this case, it would probably be "To determine the child's eligibility for First Steps based upon a referral from _____."
And
"To conduct a Family Assessment to determine the resources, priorities and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child."

Provision of Written Notice with Consent for Initiation of Early Intervention Services

Before initiating any Early Intervention Service the Service Coordinator must provide the parent with a Written Notice informing the parent of the

- The action(s) proposed
- The reason for the action

On the Notice of Action form, the service coordinator would check in front of the space for (✓)Initiation of Early Intervention Services.

Under "Reasons for the Action" the Service Coordinator would indicate the specific reason (s) for the action. In this case, it would probably be " Initiation of _____ service(s) to help reach the identified outcome(s) in the Individual Family Service Plan"

Provision of Parent's Rights Brochure

The Notice must be accompanied by copy of the Parent's Rights Brochure.

Consent Section 1

The Service Coordinator must have the parent's signature and date of the signature prior to beginning to conduct any evaluation/assessment activities or initiating any early intervention services for the child or the child's family. The Service Coordinator also must be careful to document the date the parent's signed consent was received, as no evaluation/assessment or early intervention service can begin prior to that date.

Consent Section 2

Does not apply in this case.

Provision of Notice/Consent for Initiation of Early Intervention Services

This is provided for in the IFSP document. The Service Coordinator will want to be sure that the parent is provided with a copy of the Parental Rights Brochure the first time Early Intervention Services are initiated and anytime thereafter if services are added and parental consent is required.

Provision of Notice, NO Consent Required

The service coordinator will also need to provide the parent with a Notice of Action at the other times listed below:

- If the child is found ineligible for First Step services
- If there is a change in eligibility
- If there is a change in placement (primary setting)
- Whenever there is a change in Early Intervention services (but parental consent is not required)

In the above cases, the service coordinator will check the appropriate Action that is being proposed or refused on the Notice form.

The "Reason for the Action" will be filled in.

Section 1 (consent)

Will not apply in these cases, as no parent consent is required.

Section 2

Parents in order to invoke "stay put" have 10 days from the date that an agency proposes or refuses to take an action, to file a request for a Due Process Hearing. The parent may also "waive" this 10 days if they are in agreement with the action and desire the action to be carried out immediately.

For the actions noted above, the parent will need to indicate in Section 2 if they wish to Waive the 10 days. Again, the service coordinator needs to document the date that they received the information from the parent.

Provision of Parent's Rights Brochure

A copy of the Parent's Rights Brochure must accompany the Written Notice.